Controversies, Instabilities and (Re)configurations: An actor-network account of abortion in Christchurch, New Zealand

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Abstract

Abortion is an object of enduring controversy. Perhaps not surprisingly, abortion has been the focus of a significant body of research and academic debate. This body of research has addressed abortion prevalence, methods and circulation across different localities, legislative frameworks, as well as cultural and social practices. Despite this plethora of academic literature there is an absence of material that addresses the complexities of abortion networks by considering the relationships between the human and non-human actors. This study joins an emerging trend in social work research that looks beyond the traditions of centring the person as the focus of the research endeavour to explore non-human agency. Such approaches offer new methodological possibilities for understanding human/non-human relations and the non-human actors that populate 'social' worlds.

In this thesis, Actor-network theory (ANT) is the methodological toolkit for exploring the assemblages of abortion. ANT-inflected research is distinct in the way it takes seriously the analytical currency of both human and non-human actors. Its sensibilities of 'slow research' have aided this study to closely follow the controversies that can be found where heterogeneous relationships are formed. In this way, this research has been responsive to multiplicities and contradictions that thread through articulations of abortion, and its practices.

This ethnographic study provides rich descriptions and 'snapshots' of practices at Lyndhurst Day Hospital (Lyndhurst) in Christchurch, New Zealand. The observations, interviews and document analysis on which this thesis is based were generated from the concurrent activities of research fieldwork and social work practice at Lyndhurst from 2008 to 2011. Even with a local focus, this research shows that abortion is not a stable phenomenon, but mutable, multiple, and uncertain. The descriptive text of this thesis reveals glimpses into some of the complex abortion practices and (re)configurations that emerge in and through the relational work between human and non-human actors.

The ANT-inflected descriptions in this thesis reveal that abortion controversies can be followed, and that descriptions of these controversies can extend beyond a dichotomous split. Controversies emerge in the relations between human and non-human actors, through their interests, their disagreements, and the compromises they make. Moreover, that they can be traced to reveal multiple abortion 'truths', realities, and networks.

Chapter One: Introduction

Introduction

Abortion is a global phenomenon that in its vastly diverse configurations cuts across locality, socio-economic status, legislative frameworks, and cultural, ethnic, and religious affiliation. While abortion is one of the most common gynaecological procedures in the world,[1] it is also the focus of enduring controversy. How abortion takes form, and the controversies that are part of particular abortion practices, are contingent on these societal and contextual variables.

Focusing on abortion at Lyndhurst Day Hospital (Lyndhurst) in Christchurch, New Zealand, this thesis traces some of the divergent ways in which abortion takes form. Even within the confines of this locality, abortion is not a stable phenomenon, but mutable, multiple, and uncertain. In acknowledging abortion as an unstable phenomenon, this thesis moves beyond reductive abortion dichotomies that split this reality into 'pro' and 'anti' camps to reveal the multiple ways in which abortion realities are composed. Moreover, it traverses disciplinary boundaries by following how different versions of abortion are practiced across professional networks.

The methodological approach for exploring abortion in this thesis is actor-network theory (ANT). Rather than being a prescriptive theory, ANT is a "sensibility" or set of practices that is responsive to the uncertainties of the world (Law and Singleton, 2013, p. 486). In this sense, ANT is something of a misnomer. Within this thesis, I draw upon ANT sensibilities as a means of responding to the complexities and uncertainties of abortion, and the divergent ways in which this phenomenon is assembled.

With ANT, the world is made up of an assortment of people and things – or different 'actors'. With this approach, the research imperative is to "follow the actors." This offers me an innovative means through which to consider abortion – something that is important when examining a topic that has been the focus of extensive research over a prolonged period of time. In contrast to conventional social work research where the person (or the context they live in) is afforded primary focus, the method of ANT allows the researcher to follow the work

[1] Abortion practices can be traced back, as Devereux (1955) suggests, beyond memory or record. Recent research by Sedgh, et al (2016) has indicated that there were 35 abortions per 1000 women aged 15–44 years worldwide each year in 2010–14. In New Zealand, the number of abortions per 1,000 women aged 15–44 years for New Zealand was 14.4 per 1,000 in 2014 (Statistics NZ, 2016)

of both human and non-human actors. By following human and non-human actors, I present a nuanced exploration of how abortion is assembled: accounting for the work that a range of heterogeneous actors do together and how they assemble abortion realities.

The value of this thesis is located in its descriptive account. Within this account, I show how an ANT sensibility opens up new possibilities for thinking about and doing research. ANT provides a means to attend to realites that are multiple and messy. In this way, ANT enables an exploration of abortion as a complex assemblage without the imperative of tidying up messy relations and the diverse and often competing ways in which abortion is articulated.

As ANT is a highly reflexive methodology, I start with how I encountered abortion and my place within this network. Then, I introduce the setting in which this study has emerged. A consideration of current literature on abortion is threaded through this introductory chapter and attention is afforded to broader social work and health research as a means to begin considering abortion in new ways. Then, I introduce ANT including the ways in which ANT is sensitive to divergent realities and the multiplicities of abortion assemblages. Finally, I provide an outline of the thesis chapters.

Encountering Abortion

I undertook a study of abortion as a social worker involved in the practices of abortion provision. Like Creswell, Worth and Sheikh (2010) before me, I argue that it is important for the researcher to make clear their involvement in the networks they are part of through reflexive accounts. Similar to Mol's (2008) approach of presenting 'snapshot' accounts, I too incorporate reflexive accounts of my experiences through this thesis – from my discussions of ANT as my methodology of choice, to the descriptions of participating in the work of the clinic sluice room.

As Sheehan (2011) has noted, engagement in research can emerge from the researcher's involvement in the actor-networks that they seek to explore. Similarly, Ruming (2009) argues that "ANT-centred methodology mobilises past interactions with informants for the purpose of entering and following actor-networks- interactions which are later translated by the researcher for their own purpose" (p. 460). In this way I have sought to present the early interactions and encounters that shaped my enrolment in this research, and to include snapshots of my entanglement within the abortion assemblages. Like the 'snapshots' of network connections that form the findings of ANT's descriptive accounts (Law, 2002), it is

also typical to see reflexive glimpses of the author's engagement in the research and their research journey (Law and Singleton, 2013; Mol, 2008). Whilst Chapter 2 reflects upon these glimpses as they were part of the 'doing' of this research, in this chapter I begin by offering some reflexive glimpses into how I have encountered abortion, how I gained traction for embarking in the research, and the methodology of ANT as it unfolds in this thesis.

Abortion encountered as 'absent'

I am in my very early twenties and am asked to drive a friend to an appointment. I remember three things. The first is making our way through a small but confronting assembly of people. I hear rhythmic chanting, "Don't kill your baby", don't kill your baby". We must push our way through the people, their chanting, and their signs to get to our destination. Later, I am sitting in a chair beside a hospital bed where my friend lies uncomfortable with cramps. A rubber hot water bottle sits across her lower stomach. The room is painted in light colours, stark, without adornment. I remember feeling useless, completely out of my familiar environment. Finally, I remember the quiet drive home. Our friendship continues but we never discuss this event; it is made absent.

Abortion brought into presence

Nearly ten years later, I re-enter this same setting as a social work student. My second placement is at Christchurch Women's Hospital,[2] and I am to spend several weeks at Lyndhurst Day Hospital,[3] an offsite standalone first trimester termination of pregnancy service. My inexperience with abortion is evident at my pre-placement interview when I am asked about my view of abortion.[4] I recall replying that I did not have a strong view either way, but that I did not think that abortion should be used as a form of contraception. I am firmly told that this was rarely if ever the case. I remain uncertain of the source of the 'abortion as a form of contraception' myth. I don't recall a conscious formulation of this, but I have heard this controversial phrase many times since. Despite my inexperience, I am accepted into this setting.

The setting I enter is something of a paradox – a surgical abortion service provided in an old villa on a very busy, visible corner within the four avenues of Christchurch's CBD. This time

[2] The fourth year of the Bachelor of Social Work programme at the University of Canterbury entailed two separate placements of 60 days duration.
[3] Lyndhurst Day Hospital was based offsite from other Christchurch Women's Hospital services until the 2011 Canterbury Earthquake.
[4] Prior to embarking on a social work placement within an agency, a pre-placement interview takes place between the student social worker and the social work practitioner or fieldwork educator to ascertain the student's suitability for the particular placement.

the protestors on the gate are few and intermittent. From inside the setting I observe service users flowing in and out of the building, with new faces every day. I note, doctors, nurses, nurse aids, and social workers as well as administration staff and their roles, tasks and the spaces in which they work.

I find Lyndhurst to be rich and complex. I encounter new ways of knowing abortion. I am struck by the contrast between the hidden nature of abortion practices and the regularity of unexpected pregnancy and abortion realities for women from all walks of life. I am influenced and inspired by members of the social work team at both Lyndhurst and at Christchurch Women's Hospital who I observed as a skilled group of women with professional and personal concern for the women they worked with. I too develop a keen interest in Women's Health, specifically at Lyndhurst, where the social work practice focused on pregnancy options and abortion-related counselling. Through this interest, I develop a perspective that abortion is a woman's choice within a context of complexities. I complete this placement and the following year, about six months after finishing my social work degree, a part-time position at Lyndhurst becomes available. I pursue the position and secure a permanent appointment as a social worker.

Abortion encounters as messy and uncertain

My initial explorations of a research topic for my thesis are very much concerned with the experiences of women that I was exposed to as part of my permanent social work role at Lyndhurst. However, this focus proves problematic – this role has leaky boundaries. I find that the experiences of women that I encounter as part of my social work role are not neatly confined to social work nor packaged as separate from other abortion-related realities, such as the abortion procedure and the certification of abortion that make their way into the narratives in counselling sessions. Moreover, as I proceed to explore the prospect of exploring women's experiences of abortion, I begin to note that there is a tension between the social and medical spheres of work at Lyndhurst. Though in service documentation I write "discussed social aspects of contraception" or "shown sketches of foetal development", I am not convinced that the realm of the social is discrete from other parts of the service[5]. I find myself searching for ways to account for what I am experiencing – I try to tidy up my understanding in order to make sense of it.

[5] Prior (2003) has offered an interesting insight into how patient records are selectively produced and that further to accounting for the patient situation, they also demarcate expertise and the 'ownership' of patient accounts by where notes are recorded and the scope of their content.

As a beginning social worker and researcher, I think about the practices I undertake, my social work training and the tools I use in my work to explore the narrative of service users, and the other roles and activities of abortion provision outside of my own. I wonder about exploring what women say about their experience of the service, their decision-making, how they negotiate choice and agency, the potential misunderstandings about the process of authorising abortion, and the surprises about the number of steps that are involved with abortion provision. When I reflect on mapping out decision-making or models for understanding grief on the whiteboard in my office, I consider if I should focus on the abortion decision or disenfranchised grief?[6] But what about the legislation? I worry that by focusing on one thing, I will miss how one part of abortion intersects with others and that I wont be able to provide an accurate account of what I see.

Setting the scene: Abortion in Christchurch

In order to set the scene for this study of abortion in Chrsitchurch, I start by unpacking the legal framework in which abortion is located. Then I describe counselling in abortion provision noting the intersection between legislation and counselling that requires the inclusion of social workers into abortion service provision as well as counselling services and variations concerning how these may take form. I then describe the positioning of abortion provision within public health services. Following this, I briefly describe the setting – Lyndhurst Day Hospital (Lyndhurst) and multidisciplinary team work within abortion provison. Here I also introduce some important nuances that will be teased out and elaborated upon in later chapters.

Abortion in Legislation

Legislation is not a single entity. The Contraception, Sterilization and Abortion Act 1977 (CS&A Act 1977) and amendments as well as the Crimes Act 1961 are assembled as texts and also as a contested set of practices through which abortion may be authorised (Bassett, 2001; Dixon, 2012).[7] Legislation plays a significant role in the assembling of abortion in New

[6] Doka (2002) focuses on disenfranchised grief as a type of grief or loss that may be hidden and unacknowledged by society.

[7] This section makes reference to the current context; however, it must be noted that in New Zealand as well as elsewhere the matter of establishing legal avenues to permit abortion, and that this is a legal issue at all, is one of historical and current debate. McCulloch, (2013) offers a rich account in this respect. For a report on the basis for establishing the Contraception Sterilisation and Abortion Act 1977 see *Contraception Sterilisation and Abortion in New Zealand: Report of the Royal Commission of Inquiry* March 1977. Further, Sparrow (2010; 2014) accounts for pre-legislative abortion realities in New Zealand

Zealand. For a prospective service user to access an abortion, she must meet specific legal grounds to have a request for a termination granted (Crimes Act, 1961). The doctors who are appointed as certifying consultants and specific documentation provide an interface between the requirements and obligations of these legislative entities and women as the service users.[8] Certifying consultants interpret the narratives articulated by women alongside abortion legislation in order to enact abortion – specific attention to how this occurs is discussed in Chapter 6. For women, access to an abortion requires the completion of documents for the authorisation of this request by two different Certifying Consultants, and the 'certificate' must be signed prior to the performance of an abortion procedure.

In considering legislation alone, we can already see the emergence of a network of things and people that are involved in abortion provision in New Zealand: the legislation, certificates, doctors, service users, and specific practices. Actors that have not been made present in this text thus far, but are also linked to abortion legislation, include: activists, radical feminists, protestors, women's rights movements, Members of Parliament, court buildings, medical schools that train doctors, and service premises.

The mental health grounds for authorising abortion are controversial.[9] These controversies include tensions related to reproductive choice and autonomy (Leask, 2013), the juxtaposition of mental health grounds for authorising abortion with contested claims about the relationship between abortion and mental health problems (see Baird, 2001; Leask, 2013, 2014),

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and the impetus for legislative change. Further, the Maternal Mortality Report, 1921, and the McMillan Inquiry 1937, reflect the concerns and potential for harm regarding illegally-induced abortion. The McMillan Inquiry 1937 found that approximately one in five pregnancies ended in abortion and that New Zealand had one of the highest maternal death rates for abortion in the world, reaching a quarter of all maternal mortalities as indicated from the international statistics available at the time. The results of the report brought the "private" issues of abortion into the public arena (Smyth 2000). Changes towards legalising abortion did not eventuate until the 1970's. However, various groups, for example, The Abortion Law Reform Association of New Zealand (ALRANZ), and Women's National Abortion Action Campaign (WONAAC), campaigned for legislative change.

[8] A certifying consultant is a doctor who has been appointed to this role by the Abortion Supervisory Committee (ASC). The Abortion Supervisory Committee (ASC) has the responsibility to keep under review the provisions of the abortion law in New Zealand, and the operations and effect of these provisions in practice, which includes the licensing of institutions (clinics and hospitals) for the performance of abortion and the appointment of certifying consultants (ALRANZ). The Ministry of Justice is the body under which the Abortion Supervisory Committee operates. The ASC is appointed by Parliament under the CS&A Act 1977 and consists of three members who are registered medical practitioners. The ASC produces an annual report to Parliament via the Tribunals Division of the Ministry of Justice. This annual report contains a summary of the Committees activities for the preceding year and statistical information concerning the abortion performed in the previous calendar year (ALRANZ).

[9] Of the grounds permitting abortion as described in the Contraception, Sterilisation and Abortion Act 1977, and in section 187A of the Crimes Act 1961, 98-99 percent of all abortions are performed because of serious danger to the mental health of the woman (Statistics NZ, 2014).

and also concern how legislation is interpreted and applied both in New Zealand (Basset, 2001; Dixon, 2012; Leslie, 2010) and internationally (Cook, Erdman, & Dickens, 2007; Cook, Ortega-Ortiz, Romans, & Ross, 2006). The grounds for abortion are subject to a degree of interpretation, and certifying consultants are required to make a judgment about access and the requests for services (Basset, 2001; Dixon, 2012). The law requires practitioners to make assessments in good faith, by credible standards, yet acknowledges that broad psychosocial stressors should be taken into account (Bassett, 2001). While an extensive account of the ways in which this legislation is assembled and enacted are beyond the scope of this research, a slice of these practices is described in Chapter 6, and highlights both the active role of this legislation and some of the complexities of certification.

Counselling in Abortion Provision

In New Zealand, licensed providers of abortion services are required to advise women of the right to participate in counselling under Section 35 the Contraception, Sterilisation and Abortion Act 1977. This is the case whether or not a woman ultimately has an abortion. Under Section 31 of this Act, it is the role of the Abortion Supervisory Committee to oversee that sufficient and adequate counselling services are available to women.

In New Zealand, the nature and extent of abortion counselling services is mutable and determined by the context of different localities *(*Abortion Services in New Zealand, 2006).[10] The way in which counselling is integrated into service delivery determines the extent of this work, although counselling in abortion provision should comply with the *Standards of Practice for the Provision of Counselling 1998 (*Abortion Supervisory Committee, 1998; Abortion Services in New Zealand, 2006). The 'Standards of Practice' articulate counselling as a consolidated assemblage of particular purposes, intentions, guiding principles, professional qualifications, competency certificates, professional affiliations and responsibilities, specific legislation, and counselling spaces (Abortion Supervisory Committee, 1998). They mobilise

[10] Counselling provision may include 'options counselling', 'pre-abortion counselling', and 'post-abortion counselling'. Options counselling or abortion-related counselling may be provided as a dedicated service within stand-alone clinics and purpose built units within hospitals, or as a part of a social workers generic caseload within hospitals. Moreover, some counselling services are delivered in areas that refer to major centres for abortion services and include tasks such as organising travel and accommodation for women who must travel outside of their District Health Board to access abortion services. While some abortion providers integrate counselling as a routine part of their service, in other localities counselling is discretionary. At Lyndhurst, counselling services evolved from being routine, to voluntary and again became routine. Counselling was reconfigured as a psychosocial assessment, not counselling per se, but rather a means to include counselling components, with additional counselling available on request.

further actors, such as confidentiality agreements, case notes, patient files, and the configuration of the schedules and premises in which counselling is undertaken.

According to these 'Standards of Practice', counselling services should be delivered by qualified social workers and counsellors who participate in regular supervision and are affiliated with a recognised professional association, for example the Aotearoa New Zealand Association of Social Workers (ANZASW) or the New Zealand Association of Counselling (NZAC). The wording 'should' offers an entry point to counselling controversies. In reality, there are multiple, competing and contradictory ways in which 'counselling' may take form and be practiced. Forms of 'counselling' may be offered and provided by counsellors, healthcare professionals, those in social caring roles, and laypersons. Informal/unregulated 'counselling' and support practices also featured as part of service provision in an ad hoc way which is dependent on the patient context. It is important to acknowledge that the understanding and practice of counselling is likely to vary within different disciplines and formal/informal counselling arrangements. Community services that offer counselling, information and/or support concerning pregnancy and/or women's issues, can vary in service perspectives and responses. The differences concerning who performs abortion counselling and how this takes form is a catalyst for controversies and disputes about counselling practices. Attention to some of these tensions and the mutability of abortion counselling is discussed in Chapter 4, while Chapter 6 offers a snapshot into how counselling practices were translated into service documentation.

Abortion in Health Care

District Health Boards (DHB's) are key actors that are enrolled contractually into abortion networks to fund healthcare for those who meet the eligibility criteria. This includes the obligation to provide abortion services for women who meet a further assemblage of abortion-related criteria as determined by the Crimes Act 1961 and the Contraception Sterilisation and Abortion Act 1977 (DHB Responsibilities, 2012). DHB's that do not provide abortion services directly are also drawn in to this network of funding and service provision, by generally funding and referring prospective service users to the services provided by DHB's in other localities. Specific hospitals and clinics that provide abortion services must be licensed to do so by the DHB. Moreover, similar to the variations noted with counselling practices and provision, the specific abortion services provided, and the nature of these services, vary between localities.

Abortion services in New Zealand include medical and surgical abortion procedures – specific pills, surgical instruments, techniques and spaces determine whether a procedure is surgical or medical. Surgical abortion is the most common and established procedure, and it is the procedure that was legalised as a means of abortion provision via the CS&A Act 1977. Surgical abortion is usually performed between 8 and 12 weeks of pregnancy. It involves a procedure where under local or general anaesthetic the cervix is dilated and the contents of the uterus are removed via suction aspiration. Attention to the actors involved in assembling surgical abortion is discussed in Chapter 5.

More recently in 2003, amendments were made to the CS&A ACT 1977 following the introduction of RU486 (Mifepristone or Mifegyne®). This mobilised medical abortion services for early pregnancies of up to 63 days gestation. This medication reconfigured the established mode of abortion in New Zealand as a pill-based alternative to the surgical (suction) method of abortion was made possible.[11] This medical procedure induces abortion using a combination of pharmaceuticals. At the time of this research, medical abortion was not currently available in all termination of pregnancy clinics throughout New Zealand – an example of the variance in service delivery noted earlier. Further discussion of medical abortion can be found in Chapter 7, as this relates to the insertion of a new medical abortion service into existing service provision at Lyndhurst.

The Setting: Lyndhurst Day Hospital

Lyndhurst is a first trimester termination of pregnancy service centre and gateway service centre for second trimester termination of pregnancy currently located within Christchurch Hospital. Prior to the Christchurch earthquake, and for the duration of the fieldwork phase of this study, this service operated as Lyndhurst Day Hospital from a converted villa.[12] This building was located away from other women's health services provided at Christchurch Women's Hospital as part of the publically funded services offered by the Women's Health Division of the Canterbury District Health Board.

At the time of the study, Lyndhurst provided medical termination of pregnancy up to 8 weeks and 6 days gestation, and surgical termination of pregnancy approximately between 8 and 12 weeks gestation under local anaesthetic. Lyndhurst also linked in to offsite abortion networks,

[11] The words medical and medication have been used rather than pharmaceutical to describe the pills and the procedure. The term 'medical abortion' is commonplace in the literature, and the use of the term 'medication' denotes the routine terminology used by actors in this thesis.

[12] During the writing up of this thesis, Lyndhurst was relocated as part of Christchurch Hospital.

albeit less frequently. At Lyndhurst, this involved a first certificate and then a referral offsite for surgical termination of pregnancy under general anaesthetic up to approximately 14 weeks gestation at Christchurch Women's Hospital, and a first certificate and referral offsite for second trimester induction of labour at Christchurch Women's Hospital (from approximately 14 to 20 weeks gestation). Access is considerably more limited in this latter gestational period.

A multidisciplinary team was involved in the provision of abortion services at Lyndhurst. This team included medical staff such as doctors who certified abortions and performed surgical abortion procedures, as well as nurses. Nurses supported doctors in the operating theatre, provided care for service users before and after their surgical procedure, as well as more comprehensive care concerning the practice of medical abortion. Nurse aides were active in much of the behind-the-scenes but still crucial work, such as sorting linen, preparing hospital beds, and enacting sluice room practices.[13] Social workers were based at Lyndhurst to provide counselling, information, support and referral to connected services at this site, but as part of the Christchurch Women's Social Work Team. Reception staff attended to the point of entry activities and administration. The day-to-day running of the service was the responsibility of the nurse manager whose responsibility was spilt between clinical duties and the nurse management roles. A clinical director held medical responsibility for the clinic.

These human actors could not enact abortion without the various non-human actors that were involved in this collective work – medications, medical instruments, legislation, documentation and various clinic spaces are just a few of the non-human actors key to abortion provision. In Chapter 4, particular human and non-human actors involved with assembling professional identity is discussed, as is the controversial ways in which actors entered and exited abortion assemblages.

Establishing a research focus

I chose to make use of my involvement in the field as a social worker within abortion provision and decided on a study that described specific local practices of abortion in Christchurch, rather than seeking to set up an empirical study with a view to making generalisations about abortion. I was interested in gathering rich qualitative data and revealing nuances rather than smoothing them over with a large scale survey based study.

[13] Nursing staff also undertook these tasks at times to ensure the smooth running of the service

However, I struggled to identify a methodological framework that would allow me to produce a research project that captured the complexities of abortion.

The narratives of women I met within counselling sessions at Lyndhurst provided an initial catalyst for research. Through my social work relationship with women, the complexity of abortion was certainly apparent. Within counselling sessions the dialogue traversed issues of choice, decision-making, relationships, beliefs, past reproductive experiences, the significance and realities of an embodied pregnancy, stigma, career, education, life course, stress, violence, hope and grief. However, my social work practice at Lyndhurst did not occur in a vacuum, and I was interested in activities that occurred across disciplines and in spaces that went beyond the 'counsellors office' and impacted upon service users that I engaged with. I was also interested in organisational aspects of abortion, specifically the negotiations over access to services and the agency of the service users who sought to acquire these services, and the staff who had a role in mediating this access. I struggled to limit my research focus to merely women's experiences. It was not that I did not have deep concern with the experiences of women, but rather that I was becoming stuck within the conundrum of what I could later refer to as 'cutting the network' (Strathern, 1996), and whether in doing so I was doing it prematurely. With ANT research the flow of connections between actors and the production of new networks is potentially without limit. At this early stage, which preceded my engagement with ANT methodology, I was cautious about excluding the activities of abortion provision that spilt over from my social work role.

As I became somewhat caught in the web of this entangled topic, my academic supervisors reflected that 'abortion itself' appeared to be repeatedly centrally located, and from this notion, it became clear that abortion-related social, technical, and conceptual threads weaved an 'abortion web'. What was unclear was how to approach this mess.

During the development of the research proposal, I was aware from abortion-related literature and from my social work practice at Lyndhurst that abortion is a phenomenon that is comprised of diffuse and at times competing practices, beliefs and interactions (Cohen, 2003; Jelen and Wilcox, 2003). I became attuned to abortion controversies. While there was ample literature that investigated specific aspects of abortion, such as psychological effects (Adler, 2000; Broen, Moum, Bodtker, Ekeberg, 2004; Major et al, 2008), or medical versus abortion procedures (Berer, 2005; Creinin, 2000; Say et al, 2002; Lohr, Hayes, & Gemzell-Danielsson, 2008), or legislation (Basset, 2001; Cook, Erdman, & Dickens, 2007; Cook, Ortega-Ortiz, Romans, & Ross, 2006; Dixon, 2012; Leslie, 2010), there were few examples of studies that

sought to assemble and understand the elusive textures of this complex reality. The works of authors in the abortion field to date provided impetus for a research process that explored abortion through a more inclusive lens. Hence, it was crucial that the research design was appropriate to this complex reality and that methods employed enabled this complexity to be presented and mapped.

In exploring methodologies that might 'work' for me and for this topic, I was introduced to actor-network theory by one of my supervisors. Over the following weeks, and then months, I was further guided by Law (2004) and his work on approaching complex realities. Law (2004) argues for a broadening of traditional research methods and suggests that it is not that elusive realties are beyond our grasp of understanding, but that at times they exceed our capacity to know them. Further, Law (2004) explains that it may not always be appropriate or helpful to force order on cluttered realities and omit some of the textures of which these realities are comprised. Law's work has continued to influence my thinking as I have sought a means to understand and describe abortion and its intersecting layers and trajectories.

A characteristic of much social work research is the consideration of the person within the context of their environment - that is, the people and systems that a client interacts with. Actor-network theory concurrently departs from, and extends, some of the traditional frameworks that guide social work research and practice. Actor-network theory extends social work-informed systems thinking by including non-human actors - and including them because of their significant contribution to the assembling of social worlds.

While there are studies that address social or technical aspects of abortion, there appears to be limited international, and no New Zealand research or literature that addresses abortion from a socio-technical perspective. One of several international exceptions include Clarke and Montini (1993), who in their article, 'The many faces of RU486: Tales of situated knowledges and technological contestations', engage arena analysis and actor-network theory to present the multiplicity of medical abortion, and in doing so weave together a number of actors that are part of this medical abortion network. McLaughlin (2003) draws on ANT to explore the 'common ground' of feminism and the disability movement as this relates to the antenatal screening, abortion, and ethics. On the outskirts of ANT, Joffe and Weitz (2003) make a fleeting mention of Latour (1988) and Clarke and Montini (1993) in their attention to normalising medical abortion in the US as this relates to the politics of writing such an account. However, these authors do not take up ANT as a methodological approach.

The research focus I ultimately settled upon is an experimental and innovative ethnographic and socio-technical exploration of abortion in a local setting. The methodological approach is qualitative, is informed by ANT, and employs multiple methods of data collection. ANT as an open-ended and flexible methodology has allowed me to 'follow the actors' and account for abortion as an assemblage of many human and non-human elements. The strengths and limitations of these characteristics are explored in Chapter 2. However, an introduction of ANT is useful preceding this.

Introducing ANT

The focus of this study and the methods employed are shaped not only by my knowledge of the history of abortion and the legislation, my involvement in the field, and my evolving interest in abortion, but also by the sensibilities of ANT. Actor-network theory is an innovative approach to social theory and social research that emerged from Science and Technology Studies (STS), and specifically from the work of French academics, Bruno Latour, Michel Callon, and British sociologist John Law. Rather than a fixed framework for research, Actor-network theory is an evolving theoretical repertoire of conceptual tools and sensibilities that have been 'taken up' by researchers from a range of social science disciplines and by my peers - doctoral students seeking innovative approaches to their research (see Kerr, 2010; Wilson, 2015). Despite the growing popularity of the approach, its uptake for social work research remains at a nascent stage.

A question I have often encountered while working on this thesis is "What exactly is Actor-network Theory?" Law (2007) offers a simple and engaging suggestion that ANT is not 'one thing' but a "toolkit for telling interesting stories" (p. 1). Further, I, like Nimmo (2011), suggest "that at the most general level, ANT provides a corrective to the usual social scientific focus upon human beings and the "social" domain of human "subjects", by directing attention to the significance of non-humans in social life. It suggests that social relations should not be seen in isolation, but as always existing in relations with all kinds of extra-social networks between humans and non-humans, which need to be recognized and made visible" (Latour, 1993; Michael, 2000 in Nimmo, 2011, p. 109).

The weight of this imperative, as Latour (2005; 2010) and others argue, is that the traditional and persistent nature/society divide is no longer necessary, and further, that the problem resides with the view that these are opposing. Traditionally, the social and natural are drafted

into two separate domains where their "relations of production" are erased (Law, 2007; Latour 1993; Latour & Woolgar, 1986). Instead, actor-network theorists have explored how the social and the natural 'mix' (Latour 1993, Latour & Woolgar, 1986). With ANT, nature and society are not separate, they cannot be pulled apart - there is no splitting and ascribing of value concerning human *or* non-human actors. ANT-inflected research "…doesn't necessarily distinguish very clearly between science, medicine, social science, or any other versions of inquiry" (Law, 2004, p. 18). Instead, the connections and relationships that produce certain effects, entities and actions are of concern.

Proponents and architects of ANT are often at pains to point out that there is no "society" as such. For example, Latour (2005) articulates "the social not as special domain, a specific realm, or a particular sort of thing, but only as a very peculiar movement of re-association and reassembling" (p. 7). Although frequently used in social work and other social science research, the notion of "society" suggests an exclusive relationship between human subjects. In this thesis, I am arguing that human relationships "are always mediated and transformed and even enabled by non-humans of diverse kinds, whether objects, materials, technologies, animals or eco-systems. Instead of a dualist conception of 'society' and 'nature', or 'subjects' and 'objects'" (Nimmo, 2011, p. 109). ANT exceeds the conventions of 'the social' and thus in turn acknowledges the significant role of non-humans in shaping social worlds.[14]

Following this imperative, this thesis argues that abortion cannot be solely understood by addressing people or narratives, but involves the wider networks of society, organisations, agents, texts and technologies with regards to their relationships with each other and the effects these relations have. Indeed, the central positioning of technologies in the arrangements and practices of abortion speaks to the appropriateness of an ANT approach. In this way, I am able to reveal the webs of relations in which abortion practices are produced.

Controversies

Following controversies is key to a study of abortion. As noted as part of setting the scene, attention to controversies is usually concerned with 'the' abortion controversy or debate that

[14] Whilst the theory/methods package in this thesis is ANT as a means to depart from social work research traditions and explore a 'new' way of researching and writing, I have also drawn upon elements of arena/social worlds theory, particularly the work of Star (1991; 2010) and Star and Griesemer (1989) and the notion of boundary objects as sites that gather together different social worlds. Arena/Social world's theory (see Clarke and Star, 2007) has a focus on 'collective action' and how actors with shared goals routinely and informally negotiate with each other to achieve such goals and thereby establish a social 'order'. Chapters 4 and 7, for example, describe some of this collective action.

relates to the moral, ethical, and legal status of elective abortion. Moreover, recent literature has inserted further complexities to 'the debate' with the addition of technological advances that scrutinize the foetus with greater intensity (Hopkins, Zeedyk & Raitt, 2005; Kimport and Weitz, 2015; Morgan and Michaels, 1999; Palmer, 2009; Roberts, 2012), and extend the debate to matters relating to foetal anomaly (Gammeltoft and Nguyễn, 2007; McLaughlin, 2003) and gender (see Miller, 2001). One of the consequences of framing abortion controversy in this way is that, one way or another, it inevitably splits controversy into two sides, 'pro-life' or 'pro-choice' (or their variants), or demarcate abortion into rights and wrongs. There are certainly accounts that argue that the "pro-life' and 'pro-choice' dichotomies are incomplete or of ill-fit for the complexities involved with abortion (for example Cannold, 2002). Yet, by foregrounding the key players, 'pro-life' and 'pro-choice', it is possible that many complexities remain in the shadows.

ANT looks at controversies in a different way. ANT does not start with *a priori* assumptions, frames, or categories, through which to view the world and thus determine how this might unfold. In this way, ANT is not a theory, framework or model that can be *applied* to research (Latour, 2005; Law, 2007; Nimmo, 2011). What ANT does, instead, is turn to the actors themselves in order to follow how they assemble *their* worlds (Latour, 2005).

This notion of following controversies holds potential for seeing abortion and abortion controversies in a new way instead of imposing predetermined categories of labels, Venturini (2010) refers to controversies as involving all actors, human and non-human, and that controversies can be found where heterogeneous relationships are formed. Controversies, then, are "a "hybrid forum," a space of conflict and negotiation among actors that would otherwise happily ignore each other" (p. 261). Abortion can be treated as this sort of space that pulls together diverse actors that would otherwise not encounter the other. This does not occur in a binary sense, but in a way where diverse networks of actors can be traced. This helped me move beyond abortion 'pro-life' and 'pro-choice' dichotomies, and also beyond the social work practices as part of my role in this setting to account more broadly and inclusively of abortion assemblages.

Socio-material assemblages

With ANT, particular attention is given to describing the heterogeneity of the world (Law and Singleton, 2013). The inference here is that the world is made up of an assortment of people and things – of different 'actors'. This includes human actors, people, but also non-human actors, like texts, buildings, and technologies (Law 1992; Nicolini et al 2003). Moreover,

organisations, knowledge, family, the economy and technologies, as Law's (1992) earlier work claims, are seen as effects that are generated through the relations between these actors or the heterogeneous "bits and pieces" of the social and how they combine (p. 855). In this way, by including both human and non-human actors in research inquiries, ANT provides a distinct point of departure compared with traditional accounts of "the social" or of society (Latour, 2005). In this regard, Latour (1994) premises that:

> Society is not stable enough to ascribe itself onto anything. On the contrary, most of the features of social order – scale, asymmetry, durability, power, division of labour, role distribution, and hierarchy – are impossible even to define without bringing in socialised nonhumans. Yes, society is constructed, but not just *socially* constructed (p. 793).

Conventional social science research outputs tend to overlook and underestimate non-human actors. These accounts tend to depict how human actors *use* non-humans or similarly, they minimise their contributions (Latour, 2005; Prior, 2008). Yet, as Latour (2005) and others have argued, whilst non-human actors are often neglected for what they *do*, they can and should be included alongside their human counterparts as "full-blown actors" (p. 72). With ANT, the term "actor" is inclusive of *any* actor that makes a difference or has the capacity to produce an effect – be it human or non-human (Mol, 2010). As Latour (2005) indicates below, a lack of acknowledgement of the effects of non-humans is at odds with the reality of our daily lives, let alone our research practices:

> If you can, with a straight face, maintain that hitting a nail with and without a hammer, boiling water with and without a kettle, fetching provisions with or without a basket, walking in the street with or without clothes, zapping a TV with or without a remote, slowing down a car with or without a speed-bump, keeping track of your inventory with or without bookkeeping, are exactly the same activities, that the introduction of these mundane implements change 'nothing important' to the realisation of tasks, then you are ready to transmigrate to the Far Land of the Social and disappear from this lowly one. (p. 71)

With abortion, a similar argument can be made to that of Latour (2005) above – that there is no abortion procedure without instruments, no organisation of work without service documentation, no waiting room without chairs and cubicles, no procedures without pills and instruments, no legal abortion without legislation and a certificate. Medical techniques alone

are a rich web of relations made up of actors such as the medical instruments, medication, certifying consultants, the hospital bed and particular training for example. The vast array of non-human actors that populate abortion provision is suggestive of the appropriateness of engaging an ANT methodology. Moreover, ANT also allowed me to consider networks and webby relations, particularly when thinking about qualifications, training and knowledge, and how these network consolidations are assembled as part of abortion provision.

Currently, in the literature, we can see the significance of non-humans by looking to abortion technologies. For example, RU-486 or mifepristone or Mifegyne® or 'the abortion pill' has made its way into a number of studies and accounts since its emergence in the 1970s. This 'pill' in varying arrangements with other actors has presented the possibility of a choice of abortion procedures (Berer, 2005a, 2005b; Sparrow, 2004), has reconfigured how abortion may be performed (Berer, 2005; Shand, Irvine & Iyengar, 2004; Sparrow, 2001; 2004; Goodyear-Smith, Knowles, & Masters, 2006; WHO, 2006), enabled the provision of early medical abortion service by mid-level health clinicians (Berer, 2009; Yarnall, Swica, & Winikoff, 2009), and has changed the spaces in which abortion may take place by shifting abortion out of the operating theatre and into other clinic spaces and also into the homes of women (Elul, Winikoff, & Ellertson, 1997; Hellborg, Fiala, Helström, Gemzell-Danielsson, & Winikoff, 2004).

The prospect of medical abortion has garnered interest in rural localities and developing countries where access to abortion services are not so readily available (Cooper, et al, 2005). Moreover, the new technology of pills has combined with other technologies in order for care practices to be more mobile - the World Wide Web that has mediated an online medical abortion service – Women on Web (WoW) - that exceeds the legal constraints that are present in some localities (Winikoff, & Sheldon, 2012). Recently, a further strand of this 'assemblage of care', Women on Waves, has offered abortion pills for women affected by the Zika virus. By merely providing a snapshot of abortion technologies, it is evident that abortion (or any social reality) is comprised of not merely people but non-human actors as well.

Moving beyond a 'person-centred' lens: Methodological shifts

Person-centred research, theories and practices, while shifting the person to the core of associations, inevitably separates them out from the heterogeneous webs of relations they are part of, while at the same time marginalises non-human actors for their significant contributions. As Law (1992) argues, "almost all our interactions are mediated through objects of one kind or another" (p. 3). Even the social workers at Lyndhurst who sought to enact a person-centred approach needed to assemble with a multiude of actors in order to enact social

work, such as, an office space with a door to close, a list of appointments, patient files, chairs, boxes of tissues, a pen and service documentation, their qualifications and professional affiliations, in order to bring client work into being. Moreover, they are part of wider networks that enable them to operate as social workers – multiple actors are involved in the production and maintainence of qualifications or registration, for example.

As Law (2004) explains, knowledge is constructed through practices, not by practitioners (nor clients, or organisations for that matter). Specifically, knowledge is constructed through what practitioners and others do *in action* in a relational way with other actors, including the non-human actors that are part of social worlds. Similarly, Latour and Woolgar in Laboratory Life (1986), have argued that scientists produce knowledge actively in practices. Knowledge is not produced by the scientists themselves but through their work with various apparatus, tests, etc - a heterogeneous ensemble of participants – not merely people. 'The social' is an achievement of the webs of relations that is comprised of both human and non-human actors – not one substituted for the other, but together.

Indeed, Hanssen, Hutchinson, Lyngstad, and Sandvin (2015) argued that social work knowledge and practice may be strengthened by resurrecting the notion of the 'social' in social work to include the objects that shape the conditions of client's lives. Gray, Coates and Hetherington (2013) in their edited book on environmental social work draw attention to the constraints of a person-in-environment and ecosystems perspective for neglecting the natural environment. Gray and Coates (2012), in their article on environmental ethics for social work, consider that the social work discipline may not merely have a role in the wellbeing of people but in the wellbeing and protection of non-humans - such as trees, rivers, landscapes and so on – (on this topic, see also Besthorn, 2012; Norton, 2012; Zapf, 2009).

Taking up the premise of attending to non-humans further, a cluster of social work research literature has engaged an ANT methodology and explored a broader notion of 'the social' to include the *effects* of non-humans. For example: Gray, Plath, & Webb (2009) argued how the methodology and language of evidence-based practice shapes social work practice; Doyle (2009) examined the role of inscription in social work practice with children and families; and Stanley, Du Plessis, and Austrin (2011) drew our attention to the 'black-boxing' of risk.

Symmetry

ANT-inflected (Law and Singleton, 2013) research is distinct in the way it takes seriously the analytical currency of both human and non-human actors. This imperative of *symmetry*, as Fenwick and Edwards (2010) noted, involves "treating human and non-human elements as

equally interesting, important, and capable of exerting force upon each other as they come together" (p. 146). In this way, both human *and* non-human actors can and should be described symmetrically, in the same terms, and afforded the same analytical currency for what they contribute to collective action (Latour, 2005). Through tracing relations and associations between human and non-human actors we can see that everything is entangled with everything else and together they form a network (Law and Singleton, 2013).

This notion of symmetry is not without its controversies. The imperative of affording both human and non-human actors equal analytical currency has generated the criticism that ANT dehumanises the human (see Law, 1999). ANT research does not approach fields of inquiry in order to humanise social realities nor privilege human actors in the exploration, analysis, and accounts of these realities. To include non-humans and human actors concurrently and with equal status for how they contribute to social worlds is to inevitably displace the person from the centre of events. This is a rather radical shift from the traditions of social work research that centralises the person. However, ANT does not deny the significance of people. What ANT offers is a different and more inclusive way of looking at social worlds by including non-human actors

As Mol (2010) indicates by referring to Latour's work above, the ANT metaphor of symmetry is not to do with making human and non-human actors the same or paradoxically, symmetrical. Nor does this involve attending to human and non-human actors as separate entities that are then related back to each other. Indeed, it is not to do with any division at all. What this attention to symmetry is to do with is acknowledging that 'the social' is comprised of both social *and* natural elements. Thus, by tracing the work that human and non-human actors do together, non-humans are not erased or minimised but recognised for their significant contributions to shaping social realities.

Mess

In this study, from the consideration of controversies, insights from field notes, interview data, documents and supervision dialogue, it was apparent that 'abortion' is neither an orderly phenomenon to investigate nor account for. Resisting the temptation to simplify some of these nuances, I take up the challenge set by Mol and Law (2002) to take seriously the different and at times contradictory stories that comprised reality.

In researching what Law (2004) might refer to as a 'messy world', I have sought to avoid unduly 'tidying up' abortion realities for the sake of order. Moreover, if we want to know these realities, then this requires rethinking research methods and also what we make of the worlds

that we seek to explore (Law, 2007). Law (2004) has argued that sometimes traditional methods of inquiry don't grasp the 'textures' of complex and messy worlds. As a sensibility, ANT resists the legacy of methodological hygiene and the premise that correct methods lead to singular truths and certainties, and instead seeks to be responsive in creative ways to the messiness of the world (Law, 2004).

Fenwick and Edwards (2011) acknowledge this responsiveness with regards to research in education. They state, ANT "…can open new questions and its approaches can sense phenomena in rich ways that discern the difficult ambivalences, messes, multiplicities and contradictions that are embedded in educational issues" (Fenwick and Edwards, 2011, p. 1). Similarly, ANT presents an innovative way of thinking about the multiplicity of abortion by following the configuring and reconfiguring of different abortion realities. This effort is not to do with having different *perspectives* on a phenomenon like abortion, such as 'pro-life' and 'pro-choice' perspectives. Explaining differences through perspectives, as Law (2004) argues, is a traditional stance based on the assumption that there is indeed one thing, a singular entity in which to have a perspective on. The work of Mol (2002) is influential in that she developed an alternative to responding to what she calls 'the problem of difference' – attention to multiplicities.

Multiplicity

In this thesis, I draw from Mol's (2002) concept of multiplicity as a means to be responsive to differences and the divergent ways in which abortion takes form. Service users, social workers, doctors, nurses and a plethora of other actors, will run into differences in how they encounter abortion and how they articulate what abortion is. These actors might all be involved in the provision of abortion, in one way or another, but they undertake very different practices, even within the same space. For example, in the operating theatre during an abortion procedure, the operating doctor, assisting nurse, the nurse who will sit alongside the service user, and the service user themselves, will engage in very different activities that will all be to do with the abortion procedure. In the same moment, for example, the doctor may be washing her hands, whilst the service user is placing her legs in stirrups, whilst the nurse is draping her with sterile sheets and reassuring her, whilst the other nurse is preparing the monitor at the service user's head. Thus, although differences have traditionally been considered as arising from the divergent perspectives that are held on a phenomenon, in fact, we can appreciate that we are not actually dealing with different perspectives because we are not dealing with *one thing*.

From the example above, we can see that an abortion procedure is not assembled from the same sets of practices for each of these actors in this textured event. The service user and the doctor for example, do not have a different perspective on the abortion procedure in the operating theatre, but are engaged in an entirely different set of practices and come from vastly different worlds. These worlds may align, or as Mol (2010) suggests, what may be present is different "networks", that exist simultaneously in tension.

This notion of multiplicity offers a new way of being responsive to abortion where discovering the 'truth' about abortion is not an imperative. This is precisely because abortion cannot be considered as a singular reality. Because abortion is enacted in and through different practices, there is no 'abortion' that is common, that is definite, and that is one thing (Law, 2004). A further way in which the textures of abortion are captured is through the concept of 'Method Assemblage' (Law, 2004), discussed next.

Presence, Absence and Otherness

Earlier in this introductory chapter I noted how I had initially encountered abortion. Here I alluded to abortion as something that was made both present and absent. To revisit this and extend this notion further, I draw on Law's (2004) notion of Method Assemblage as a concept of importance to the descriptions in this thesis.

Method assemblage, in brief, is the "the process of crafting and enacting the necessary boundaries between present, manifest absence, and otherness" (Law, 2004, p. 161). To begin to break this down a little, the 'crafting and enacting' of method assemblage infers that presence and absence is both produced or 'cultivated' (Mol, 2013), as well as performed or 'practiced' (Mol, 2002). A key difference between method assemblage and assemblage is its attention to the generation of assemblage. As Law (2004) stresses, methods help describe particular realities but they also create them. These generative and enacted relations of method assemblage, as Law (2004) has described, are bundled or gathered into three parts.

The first refers to that which is 'in-here' and made present. This can refer to a representation. Linking back to my encountering of abortion, when I accompanied a friend to Lyndhurst in my early twenties, a representation of abortion was brought into presence. This representation emerged through the relations between materials – signs, the hot water bottle, stark walls – and the people – protestors, two friends. Later, abortion is enacted into presence again, as part of my social work training and then as part of my professional identity. Chapter 4 attends specifically to the interplay of absence and presence (Law, 2004), and the 'material mediators' that construct professional identities (Jerolmack and Tavory, 2014).

The second part of the 'bundling of relations' is to do with what is made absent but manifest – so an absence that can be described, or seen, or talked about. For example, my friend and I entered the premises at Lyndhurst and the protestors exclaimed "don't kill your baby". By bringing this representation of abortion into presence, then what was made absent but can be articulated was a representation of abortion to do with reproductive autonomy for example, as discussed briefly earlier in the chapter with reference to abortion literature. Moreover, the representation that was made present is cultivated in front of the setting of abortion provision – a setting made absent from the phrase 'don't kill your baby' but nonetheless visible and describable.

The third part of this bundling of relations is what is made absent but is hidden and thus, 'Othered', either because it is uninteresting or repressed (Law, 2004). For example, when I encounter abortion initially with my friend, and a version of abortion is brought into presence, as we do not talk about it, abortion is at the same time made absent in a particular way where it is repressed and othered.

Further to this, there is another type of presence at play and a different sort of representation – that of allegory (Law, 2004). Allegory, as Law (2004) describes it, refers to what has not been said and what has not been acknowledged, but is made manifest by 'reading between the lines.' As one example, a reader may assume that I have not encountered abortion as a service user. I do not say this, but this is implied - as a further enactment of reality.

These enactments of reality must be accounted for. With ANT, description is the means for accounting for this work rather than by way of explanation (Latour, 2005). There is an emphasis on accounting for action. The focus of a descriptive account is on emphasising the 'how': how actors frame their worlds, how worlds are generated, ordered, and configured. Putting the field into words is an example of translation, the final concept in this introductory chapter.

Translation

The notion of translation, an important feature on the ANT landscape. Indeed, ANT has also been articulated as 'the sociology of translation' (Callon, 1986, Latour, 2005). Tracing translations is a means to reveal how stability may be achieved through the work of heterogeneous actors, even if this stability is fleeting (Callon, 1986; Law, 1992). In this way, the process of translation may not produce an enduring stability.

Latour (1999) has argued that when "we pack the world into words" (or other achievements), this occurs through a series of movements or translations (p. 24). So, the production of this thesis, for example, and shifting the assemblage of abortion into this text, is a form of translation where the outcome of research activities (this work that arises through relations between human and non-human actors) culminates in a textual stable entity – an 'immutable mobile' (Latour, 2005). Chapter 7 attends explicitly to this notion by drawing attention to how abortion provision is produced in service documentation.

However, through the movements that are required to shift the world into text, there are also betrayals – losses and disloyalties that are produced in the production of network consolidations. Law (2009) captures this notion of betrayal in his description of translation: "To translate is to make two words equivalent. But since no two words are equivalent, translation also implies betrayal: traduction, trahison. So translation is both about making equivalent, and about shifting. It is about moving terms around, about linking and changing them" (p. 144). Chapter 6 specifically discusses translation and the ways that complex sets of practices are modified and shifted into new forms, such as service documentation. Moreover, because it is not possible to account for everything in text, then through the process of translation there is a reconfiguration of abortion, where in the production of a textual account, practice complexities are left behind.

Thesis Outline

As I have noted above, ANT has a particular focus on the socio-material and on the relations between 'actors', the people and things that 'make up' social worlds. These actors culminate in what is referred to as relational 'webs', 'networks' or assemblages' (Latour, 2005; Law, and Singleton, 2013). The method of ANT involves 'following the actors', both human and non-human, to trace and describe what these actors do together and how the relations between these actors bring about specific social realities. I have taken up ANT's attention to materiality by focusing on the objects, bodies and matter that comprise abortion alongside their human counterparts. Drawing on ANT, this thesis examines the diverse ways in which abortion is socio-materially assembled, with the emphasis being on how these assemblages take form.

Following the introduction to ANT provided in this chapter, Chapter 2 develops some of the key features of ANT to reveal how these concepts translated into the methodological practices of this study. It has been suggested that ANT "is more widely known than well understood"

(Nimmo, 2011, p.108), and in Chapter 2 I introduce the 'version' of ANT I am using to study abortion. I unpack how I started this research 'in the middle of the action' as a social worker in abortion provision. By engaging the sensibilities of ANT, I was alerted to new ways of 'seeing' abortion as I both grappled with and embraced the attention to symmetry that ANT requires. Attention to reflexivity is key in that I acknowledge how I gathered and sorted the data, my place within an abortion assemblage and my hand in the production of this thesis.

Chapter 3 follows abortion controversies via specific articulations of an 'abortion-related pregnancy' to illustrate how 'truths', and 'facts', are actively assembled, disputed, and reassembled. Firstly, by following the cultivation of wording and wording disputes between service users, professionals, and texts, this chapter reveals an absence of stable and common vocabulary through which to talk about an 'abortion-related pregnancy'. Then, the reshaping of wording is linked to the reshaping of the pregnancy itself and the different practices that actors engage in. Accordingly, even within the clinic setting there exists a plethora of wording dependant on the arrangements between actors, practices and work spaces. Finally, the chapter follows the enactment of devices - foetal models and protester pamphlets - that exceed their materiality to articulate a version of the abortion-related pregnancy on behalf of their human counterparts. The 'abortion-related pregnancy' proves to imbue name-changing, shape-changing qualities, that emerge in human/non-human relations and practices.

Chapter 4 continues the attention to heterogeneity where professional identity is argued as something that emerges in and through the relations between human and non-human actors. At the gateway to Lyndhurst and through attention to medical apparatus, building spaces, and décor, non-humans are revealed as actors that may mediate and disrupt professional identity. Further various totems and practices are involved in enacting professional identity through various arrangements of presence, absence and otherness. Finally, by drawing on the network consolidation of 'social work', this chapter reveals that professional identity proves unstable and is configured and reconfigured in varying practice arrangements.

Chapter 5 follows the 'body-in-practice' to examine how 'the' body of the service user multiplies as it is configured and reconfigured in different practices and sites of abortion provision. It begins by attending to the unruliness of the body and how contraceptive devices and treatment are enrolled in an attempt to order the body, despite these efforts not always being successful. Next, attention to texts reveals how the body exceeds its fleshy reality and is translated into texts that make a version of the body accessible and transportable across professional actors and sites. Finally, in the practice arrangements of the operating theatre,

this chapter focuses on dynamic arrangements of the body as subject and object as an effect of complex practice relations.

Chapter 6 examines the complex process of movement from one point to another in an abortion trajectory and the circulation of the service user through service provision. It focuses on how abortion is comprised of a series of end-to-end practices where a process of translation is necessary in order to 'move' abortion practices from one point to the next. This 'translation' is important to bridging the gaps between some of the different sets of practices described thus far and to show the production and consolidation of a socio-technical assemblage. Accordingly, this chapter attends in detail to how connected sets of abortion actors, practices and devices work to 'filter' the 'world' into documentation. However, we are also alerted to the uncertainties that sit behind inscriptions and the ways in which actors may 'act back'.

Chapter 7 follows the presence of a 'new' technology for local abortion provision - medical abortion, a pill-based abortion method. A medical abortion service did not simply slot into existing service provision, but reconfigured actors, mobilised new care responsibilities, abortion knowledge, care practices and spaces of abortion provision. Ongoing and purposeful 'tinkering' was required in order to navigate the intentions and tensions that emerged in action. The disruptions that are explored in Chapter 5 and devices of Chapter 6 carry over to this chapter where we are alerted to how technologies 'act' and indeed 'act back' in various arrangements of care. The 'attentive experimentation' of collective 'tinkering' is revealed as necessary to improve the provision of abortion care (see Mol, Moser and Pols, 2010). This involves 'compromise' where actors come together to produce a new assemblage that suits their diverse aims and needs.

Lastly, Chapter 8 reflects on the textual outcome of this study. It considers what ANT offers as a research approach for studying abortion. Further, it consider what might be learnt from following both human and non-human actors and the descriptive means through which this collective work is stabilised. Finally, it contemplates the value of ANT as an innovative 'toolkit' of methods for social work research.

Chapter Two: Methodology

Introduction

Actor Network Theory has become increasingly popular with social scientists and, indeed, with my peers - doctoral students seeking innovative approaches to their research (see Kerr, 2010; Wilson, 2015). While the name might suggest a theoretical unity, ANT is actually a rather complex theoretical formation with many variations (Nimmo, 2011). With that in mind, this study could be thought of as an experiment in using ANT for social work research, to reveal the complexities of abortion provision. In this endeavour, I do not apply a theory or framework to the research since ANT constitutes a "divergent set of practices" that continues to evolve (see Law, 2004, p4); rather, I am guided by the sensibilities of ANT to slowly and carefully 'follow the actors' (Latour, 1987; 2005). This 'following' the action of actors provided me an opportunity to trace how abortion work was enacted within multiple sites of practice. Moreover, like Perez-y-Perez (2015) and Wilson (2015), these detective-like methods of following, tracing and mapping links between heterogeneous actors led to 'ethnographic surprises' that illuminated unexpected forms of power that determined practice arrangements.

My adoption and adaptation of ANT sensibilities presents a particular "version" of ANT. In this chapter I describe some of the ways in which I have sought to 'capture' some of the webs of human and non-human relations in the assemblage of abortion. Adopting ANT sensibilities allowed me to appreciate the significant role of non-humans, and that all elements in a network are actors in their own right and can and should be described in the same terms (Latour, 2005). In this way, I was able to put aside notions about the character of actors, and instead, proceed to follow the connections formed between actors to document the assemblages, knowledge, and practices that have often been over looked in previous accounts of abortion.

This chapter begins by discussing how ANT, as an innovative approach to social work research, allowed me to appreciate a messy methodological reality. I then proceed to account for my involvement in the setting. My 'multiple and shifting identities' enabled me to cultivate relationships with actors in the setting of Lyndhurst and make links to other actors, for example, referrers to Lyndhurst, 'pro-life' and 'pro-choice' groups in the community, and other abortion services in New Zealand. Next, I account for my experiences in using and grappling with the conceptual tools and research methods of ANT. I begin with how I selected actors

and sites to follow, where I entered the field, and where I decided to stop tracing abortion networks. A key aspect of this data collection was the method of participant observation. I discuss how my engagement with ANT informed the participant observation process. Finally, I account for the process of assembling and translating the data into text.

Applying ANT Sensibility: Embracing Multiplicities and Mess

Like other researchers, my adoption of ANT sensibilities presents a particular "version" of ANT. It would not be accurate for me to assert that this approach is the "right" or "only" one. As Nimmo (2011) suggests, to do that "would be a rather sterile – not to mention very un-ANT-ish – sort of exercise" (p.109).

Similarly, Best & Walters (2013, p. 332) note:

> [l]ike any multiplicity, "actor-network theory" is many things: an influential current within the sociology of science and technology; a relational and anti-essentialist form of materialism; an insistence that notions of agency not be confined to human subjects but embrace objects, devices, and other non-human entities; and much else besides.

As I began this research, I found it useful to think of ANT as an intellectual "toolkit" or "sensibility" (Law, 2004, 157). It orientates the researcher to new ways of asking questions, of approaching research, analysis and writing (see Law and Singleton, 2013; Mol, 2010). As such, it is a way of sensing or getting close to particular phenomenon (Fenwick and Edwards, 2012). Our attention is drawn to the numerous 'everyday' ways that non-humans guide, enable, and constrain social life; ANT encourages us to see the ways in which non-humans mediate everyday life, and how they "transform, translate, distort, and modify the meaning or the elements they are supposed to carry" (Latour 2005:39). Thus, the sensibilities of ANT afforded me an innovative approach to studying abortion provision. Following Law (2007), I discovered that the flexibility of ANT as a mutable 'toolkit' of methods could be tailored to attend to specific fields of inquiry – abortion practices.

For ANT researchers, a central point of focus is on the world-building capacities of the actors themselves (see Latour, 1999a; Latour, 2005). As Law (1994) suggested, we are what we are by

virtue of our associations (see p, 100–101) in the ways that 'our' identities, thoughts, and actions are produced and spread through people, things, situations, and structures (see also Jerolmack and Tavory, 2014). Indeed, a turn to ANT sensibilities showed me how a given entity can be (re) produced by examining how people, things and knowledge spread, circulate and connect to form webs of relations or 'assemblages'. Moreover, I noted how utilising the notion of the assemblage essentially reverses our conventional conceptions of agency (see Law, 1994).

Through seeing abortion as a network of continuously shifting assemblages, its unstable qualities are revealed. ANT can be very useful when we are faced with inevitable innovations, new objects, or concepts in a field (Bueger and Bethke, 2013). Kerr (2010) talked about this in relation to high performance gymnastics, and it is equally relevant to abortion assemblages: Health services frequently have policy and procedural changes that affect how a service operates, as well as the introduction of new technologies, medicines, or debates. ANT offers, in essence, a "search and find" strategy that encourages us to look elsewhere than we usually do.

This research, and ultimately the thesis itself, 'follows' abortion networks through tracing various actors and their practices. It is clearly not possible to follow the actors everywhere as it is not feasible for the researcher to track every actor at all times and in every practice they are engaged in. For example, it is not possible to "follow" medical instruments into the sterilisation machine. Nor is it possible to follow consultants home, or follow pamphlets that are being printed at a local copy centre. Like Kerr (2010) discusses, following is not all-inclusive but refers to a "mapping of the moments" (Michael, 2000, p. 131) when the researcher is alerted to the presence of actors and practices as they feature as part of various assemblages. In this way, this research maps some of the moments in which abortion assemblages transpire.

Nimmo (2011) argues that ANT has increasingly been seen as the 'go to' approach for researchers interested in taking seriously the role of "nonhumans" in social life. Like Nimmo's (2011) work on the history of milk, my research involves an exploration of how ANT can be mobilised in social work research, "in terms of what kinds of knowledge-practices it enables and what sorts of methodological possibilities it opens up" (p. 108-9).

As Mol (2010) argues, by taking up ANT-inspired research I should not merely replicate the existing ANT arguments and cases that have come before, but contribute to the gentle shifting of its theoretical repertoire. By employing my version of ANT, I enter into this unfolding and contribute in some small way to its evolving sensibilities. In this way, this research is not simply an "application" of ANT (Nimmo, 2011) - even if such a thing were possible, or

desirable. Indeed, as, Sørensen (2009: 12) argues, '[t]he logical meaning and coherence of the concepts we use is less important: what is crucial is how they help us do empirical studies and analyses and the kinds of studies and analyses in which they result" (in Fenwick and Edwards, 2010, p. 144).

My version of ANT draws upon the methodologies and concepts of traditional ANT and After-ANT adaptations. I draw largely on the work of Latour (1991; 1999; 2005; 2010), Law (2004; 2007), Law and Singleton (2005; 2013), Mol (2002; 2008), and Mol, Moser and Pols (2010). The methods and tools I have selected as part of the repertoire of ANT devices have facilitated an analysis and description of abortion as a collection of dynamic socio-material relations and practices. I followed the actors invested in abortion, and their relations and practices, in multiple spaces throughout the duration of my fieldwork by employing ethnographical methods of participant observation, semi-structured interviews, and document analysis. An 'ANT-inflected' (Law and Singleton, 2013) approach to gathering data, analysis, and writing, afforded the unpacking and revealing of some of the complexities of abortion and of various abortion configurations.[15]

Due to the strategies employed, this thesis offers a specific account of abortion practices, while other research strategies and methods would have inevitably provided alternative accounts. Accordingly, attention is given to reflexivity in order to explicitly account for the means through which this version of abortion is assembled. With an ANT approach, the researcher features as part of the landscape. I was definitely a part of the landscape of my research – I was a social worker at Lyndhurst.

In her doctoral research, Kerr (2010) reflects on Latour's (1995) argument that we should learn from the actors in our research. Like me, Kerr (2010) reflects on how much she has learnt about things that she previously believed she knew a lot about – or, perhaps, realised how much cannot be 'known'. At different points in this thesis, I reveal the limitations of my involvement as a 'practitioner-researcher' and the ways in which I was a stranger to many of the practices I followed in the 'familiar environment' of abortion provision. In this chapter, I make clear how I was involved in the field, how I negotiated 'following the actors', and the point at which I left the research setting. In doing so, I trace how I got to grips with a research approach that challenged me to embrace the agency of non-human actors, to tolerate the

[15] The term 'ANT-inflected' is from Law and Singleton (2013) who, as a number of ANT authors do in various ways, draw attention to ANT as a sensibility and a practice rather than a pre-existing 'theory' that can be 'applied' to field of inquiry.

messiness of complex realities, and appreciate the 'ethnographic surprises' as I followed the complex arrangements of abortion practices.

Importantly, the development of an ANT sensibility allowed me to focus on working *in* the world and being sensitive *to* the world (see Ingold, 2011). In this way, I was able to put aside ideas about the character of actors and attune to how actors become assembled through practices and their relations within these assemblages.

In the production of this text, I have abstained from tidying up the accounts of actors by fixing a theoretical frame. Moreover, in developing an ANT sensibility, I sought to describe the multiple and divergent ways in which I observed abortion to take form. This document is a "product" of a research endeavour, and as such, is an assemblage of a kaleidoscopic textual account, a gathering of ANT-inflected stories about abortion, and a thesis.

Embracing Methodological Mess

In contrast to the 'clean and clear' networks of early ANT studies, current versions of ANT have moved away from the notion of singularity towards accounting for instability and multiplicity (Singleton and Michael, 1993). Law (2004), in particular, has argued for research methods that do not 'tidy up' or repress the inevitable mess and heterogeneity that research is actually comprised of. Law (2004) argues:

> ANT…lets us to see the relative messiness in practice. It looks behind the official accounts of method (which are often clean and reassuring) to try and understand the often ragged ways in which knowledge is produced in research (p. 18).

Perhaps not surprisingly, 'clean and reassuring' accounts from the field tend to emerge in documentation that circulates within abortion provision networks. Much of the documentation produced in abortion provision attempts to provide an 'official' and orderly account of how a service user moves through the service and the professions and professional practices that help mediate this. However, what is produced in text does not quite capture the translation of various activities into text (Latour, 1999), nor the multitude of practices 'made absent' by producing this account (Law, 2004). For example, administrative work, sluice room practices, and the 'tinkering' activities and collective work of human and non-human actors do not make it into this orderly textual product. What ANT offers, in this respect, is a broadening of the action that may comprise social worlds to attend to and account for that which may conventionally be overlooked.

By engaging in an active process of ethnographic discovery with an ANT sensibility, I suggest that predefined boundaries of inquiry about how abortion was assembled would be misleading. Over the course of this research, I followed the arrangements of different practices - whether these typified the social work discipline that was more familiar to me, or the less familiar medical, administrative, and technical sites of work.

I turned to the actors themselves, and sought to be responsive to their "world-building capacities" (Latour, 1999). Accordingly, I focused on what various actors did and how they shaped this world of abortion. I did not 'tidy up' the field by narrowing down who or what was included as relevant to assembling abortion, nor prematurely exclude parts of the action. Embracing the messiness of research practice was essential to the fieldwork I undertook. By embracing the 'messiness' of the field, I was able to follow multiple realities enacted in and through different practices (Mol, 2002). However, the "data" collected for this research far exceeded what I assumed I would find, which proved to add both stimulating and challenging elements to the research process.

Initially, I struggled to tolerate the messiness and the sheer volume of actors involved in the assemblage of abortion networks. While this was not a boundary-less inquiry, there were seemingly endless possibilities within my fieldwork. At first I sought to keep separate my social work and research activities at Lyndhurst. I did this by reinserting myself into the field as a 'researcher' on Thursdays when I was not scheduled to be at Lyndhurst in my social work role. Unexpectedly, I found that this arrangement of a 'research day' enacted me as an oddity and as 'other'. It seemed 'unnatural' to set a rigid divide between roles and activities. Thus, I abandoned this initiative of a separate observation day after several weeks, and I resolved to tolerate or at least endure the discomfort of the messiness that was my methodological reality. In this way, like Barnacle and Mewburn (2010), I found my research "was enacted 'in the gaps' of everyday life" (p. 437). In order to grasp the observational opportunities that arose in the course of day-to-day work, I had to acquiesce clean boundaries and embrace 'leaky methodological borders', and a more mutable and messy research reality where I moved back and forth between overlapping social work and research activities[16].

[16] One of the boundaries that *was* enforced from inception as part of my application for ethics approval and in practice was to forge a divide between my research activities and my client work. Scheduled counselling appointments, referrals, follow up phone calls, consultation with other staff about clients, and such that were part of my social work role at Lyndhurst were not 'on the table' as data and I did not to make fieldnotes from these client interactions. I also excluded myself from directly recruiting of service users for interviews and observations. Staff at Lyndhurst mediated this without my presence.

The bulk of my fieldwork at Lyndhurst occurred during the period when counselling was optional. My early social work practice involved sporadic appointments, few busy days, and frequent and often lengthy gaps between appointments. At these times I stretched the borders between my social work and research role. For example, this stretching took place when I sought clarification about a practice I had observed, or when the opportunity for an observation outside of my usual working practices arose. While these occurrences were often impromptu and conducted in consultation with the nurse manager and other staff, I sometimes felt guilty 'using' time allocated to my paid social work role. But, not guilty enough not to proceed and grasp opportunities as they presented themselves.

Following abortion actors, practices, and controversies

Singleton (1998) noted that the starting point of one's study is arbitrary; it is due to the choices made by the researcher. So with the start and end of research being somewhat arbitrary, there are multiple possibilities for entry to specific networks, and these are largely shaped by the decisions that I as the researcher make. As Latour (2005) suggests, "We start in the middle of things…Action had already started; it will continue when we are no longer around" (p. 123). Thus, following Latour (2005), my entry into this research could be described as being somewhat in the middle of the action. I had been employed as a social worker (part-time) at Lyndhurst in 2008, about a year prior to the commencement of the research, and remained there until the beginning of 2011. Thus, I was already part of the assemblage of abortion that I sought to map and follow. Like Perez-y-Perez (2015), I made use of my inclusion in this assemblage to establish connections with significant actors, or rather these actors approaching me and then following these actors.

Deciding where to begin, where to go, and what to follow was initially reliant on the boundary making capacities of the actors within the Lyndhurst setting. Though I was part of the Lyndhurst staff/team, I could not move freely through all sites of practice without permission or guidance of the social and material actors who inhabited these sites. For example, as the study progressed, I negotiated several observations in theatre with the nurse manager. However, whilst this actor granted permission, I was also required to gain consent from theatre staff – often a doctor and nurses. Then, it was a case of whether a service user would consent to my presence. After this, it was not just a matter of walking into theatre; I also

needed entry to the changing room, where a nurse sorted through the faded but neatly folded sets of scrubs, and passed me a set that would fit.

This first observation of theatre took me by surprise, and as I got changed I found that I did not have the right shoes for the setting – black strappy heels. I had no choice but to explain my dilemma to a nurse who then rummaged around in lockers to find another nurse's theatre shoes around my size so I could be part of the theatre assemblage. It was not just the human actors that permitted me to enter various spaces. As described, non-human actors like a pair of clog-like shoes were the difference between inclusion and exclusion to the operating theatre on this occasion.

Guidance was also important given the diverse sets of practices. For example, for my initial observation in theatre, I received instructions and am assembled by nursing staff as the field notes below describe:

> *…the nurse shoves a couple of barley sugar lollies in my hand. "Put these in your pocket and take one if you feel faint. Sit at the head [of the service user] and when you feel comfortable, go down to the doctor. Don't worry if you feel dizzy – it gets hot in there". She then shares a story as she recalls a medical student who was observing for the morning lying on the floor of the operating room still talking with the doctor about the nature of the procedure. She ushers me into theatre, one of the theatre nurses looks up, reaches for a wheeled stool and flicks it across the floor to me "grab a seat" she says.*

In order to take part in the practices in the operating theatre at Lyndhurst, I had to learn how to conduct myself and how to 'be' in the spaces that were outside of my social work role. I was guided by staff who had prior understanding of the effects of entering the space of the operating theatre, such as in the example of the medical student given above. I could not simply 'rush in' but was slowly assembled with material actors, lollies and a seat, and directed how to move through the space, starting at one part of theatre, where specific theatre actors and practices were gathered, and when comfortable, moving to another, that involved different actors and practices. This both eased my entry into this setting and alerted me to actors and arrangements beyond what I had anticipated.

As noted earlier in this chapter, I did not order abortion practice by applying a theory or framework to the research, but, guided by ANT sensibilities, I sought to 'follow the actors' (Latour, 1987; 2005). This notion is what Law and Singleton (2013) develop in their articulation

of 'slow research'. As Law and Singleton (2013) suggest, 'slow research' is research that stays with the action and does not predetermine which actors have analytical currency. Slow research, rather than leaping ahead to explain the field of inquiry, is sensitive to 'ethnographic surprises' and the uncertainties that present in the course of the research journey (Law and Singleton, 2013). As I engaged in the activities of following, ANT allowed me to follow different actors, to move between sites, and explore some of the diverse practices that abortion was made up of. I chose to do this to concurrently capture the different and divergent ways in which abortion was enacted – or what Mol (2002) refers to as *multiplicity*. Mol (2002) shows that practices do not necessarily reduce and come together to form a single reality but that different practices produce not only different perspectives but also different realities even for what seem like single-disease conditions. For Mol (2002) this condition is atherosclerosis, yet I suggest the same argument prevails for abortion.

The imperative of following vastly opened up the possibilities for researching abortion. The open qualities of following meant that whilst this is a social work thesis, it is not bound to the discipline of social work as it pertains to abortion provision. Nor did the research centre on the accounts of abortion by women whose experiences were the focus of my social work practice. In this way, I offer something different from the person-centred focus that social work and counselling literature on abortion typically attends to. ANT's inclusion of non-human actors and its focus on tracing the relations between actors enabled me to be responsive to both *who* and *what* played a part in assembling social workers and social work practice. I was able to follow actors and traverse sites beyond those I circulated as a social worker and thus, stretched the 'knowledge' of the setting I held at the outset of the project.

Negotiating Inclusion

At Lyndhurst, social workers repeatedly trafficked certain spaces, such as the reception desk, waiting room and their offices, but less frequently entered others. The back office, the ward, nurses' station, the sluice room and operating theatre were examples of sites that as a social worker I knew about and had momentarily entered, but were also places where the specific practices generated at these sites had little to do with my social work role. I was not 'familiar' with the rich assemblages of actors and practices in spaces that I lacked direct involvement with in the conduct of my social work role. Thus, I had to come to terms not only with the limitations of my abortion knowledge, but also with the insight that my access to the field, in spite of my prior inclusion in the field, was not all-encompassing. In many ways, I was a stranger in a familiar environment. The practice of following, however, encouraged me to

encounter some of these less familiar actors and practices. My following of sluice room activities illustrate this notion.

The sluice room was a site of action with understated social and analytical currency. As Latour (2005) indicates, it is a mistake to 'ignore' data that has less 'social' visibility. Indeed, sluice room activities, whilst highly controversial because of the bodily substances that circulate within this space, are afforded little prominence as part of abortion provision and in the research literature about abortion. However, with ANT, to come to know 'the social', one cannot omit part of the action and must "travel wherever new heterogeneous associations are made" (Latour, 2005, p. 8). So, it is certainly possible to follow the 'loud' actors within a network and produce an account from this way of 'seeing' the world (Law, 1991; Quinlan, 2012). Indeed, early ANT was criticised for this very tendency (Fenwick, 2010). However, a focus on dominant actors, as Star (1991) and Wajcman (2000) both argue, inevitably risks excluding those located on the margins. Further, as Star (1991) asserts, attending to those on the margins can present a reality that may well have been otherwise.

Thus I learned not to simply foreground actors on the margins, but to engage in the slow, careful, process of following in order to be responsive to multiple actors, to capture the multiplicities of abortion without prematurely reducing the scope of this world. With this in mind, following the activities of abortion into the sluice room was imperative: the activities of the sluice room connected to the more obvious abortion activities such as operating theatre practices and counselling sessions. Hence, the sluice room at Lyndhurst presented as a relevant site of inquiry – albeit one I had not anticipated at the outset of the project.

I negotiated to spend time in the sluice room alongside the nurse aid. In the sluice room, various 'things' circulated and (re)assembled. Stainless steel trolleys transport used and soiled linens that were sorted into various bins, medical equipment was unpacked, washed, repacked, and sent offsite for sterilisation, and the 'products of conception' (POC's) were sorted and either returned to service users in pottles, or sent away for disposal. In the sluice room, I also had the opportunity to 'get my hands dirty' and 'follow the actors' with unanticipated proximity.

The work of the sluice room that I encountered was a contrast to the work I performed as a social worker. The sluice room setting introduced me to different webs of relations that included new sets of actors, and excluded others. I was required to assemble myself like the nurse aid I shadowed by putting on blue scrubs, placing clear goggles over my prescription glasses, and putting on a white plastic apron and latex gloves. The overlay of materials was

imperative – I could not do the work of the sluice room without this arrangement. Thus, I was enacted to handle and wash equipment and came into direct contact with the bodily substances of blood and tissue that theatre staff and the nurse aid interact with. When the morning list finished, getting out of the attire of the sluice room enabled me to access other actors and settings within Lyndhurst. I could not simply walk out of the sluice room and join the receptionist or see a client for a counselling appointment in this ensemble of an apron and googles and gloves.

The activities of the sluice room allowed me to gain insight to some of the specific nuances of abortion that I would not usually encounter. Just as Law (1992) notes, we are only sometimes aware of the networks that lie behind and make up an actor, an object or an institution, and often we are not in the position to observe network complexities. Participating in the practices of the sluice room offered me deeper analytical insights of the collective I was part of in spaces that were outside of the activities of my day-today working role. For example:

> *Nurse Aid:* "The set's coming now, how are you feeling?"
>
> *Letitia:* "I'm ok"
>
> *A nurse pushed the trolley towards us. Sheets were piled on top of what I assumed was the used medical equipment from theatre. The nurse removed the top sheet and put it in a bin (for unstained sheets); the second bloodied sheet was placed in another bin. The pottle containing pregnancy tissue is removed and detached from plastic tubes and each part placed in separate medical waste bins. The nurse then removed the assorted medical equipment from the tray and puts it into the sink of about 15cms of soapy water. She then pushes the trolley back to theatre.*
>
> *Nurse Aid:* "Wash or dry"
>
> *Letitia:* "I'll wash"

My inclusion in the sluice room also proved to be a way of building connections and enabling further observations to take place. In addition to the rich research material that the site of the sluice room presented in its own right, what transpired from this participation proved to be an 'ethnographic surprise' (Law and Singleton, 2013). Through the *doing* of research I learned about becoming sensitive to contingent arrangements of power and how power was generated relationally (Law and Singleton, 2013). Like Law and Singleton (2013) discuss, my 'power to act' as a researcher endeavouring to explore abortion networks was something that was woven

together and emergent from the relational work that I did with actors and in the practices we undertook. The sluice room activities provide a key illustration of how power can be distributed across actors, practices and sites:

> *...Several nurses approached me and asked how I found shadowing the nurse aid in the sluice room the previous day. This occurred again in the staff room followed by silence by the nursing staff present and I suspected that there was interest in how I had coped. I responded that it was "really good" and I had found it "interesting". I had enjoyed getting to know a bit about what other staff members do in that on one hand we are part of the same team but in our day to day work we rarely get to see the specific work that others do. I explained that the sluice room had been an arrangement of unfamiliar equipment and that now I had some understanding of how things worked and the roles of others. One of the nurses joked that they would get me in there when the nurse aid was away. The nurse manager then asked if I would like to shadow some of the nurses in recovery or perhaps follow a patient through the service. I responded that that would be really good. She said "ok, we'll get you into some blues and get you in there".*

My sluice room participation became a pivotal experience. Whilst I was already 'in' the field as a social worker at Lyndhurst, my participation in the sluice room enabled me to 'get in' to the field I sought to study. In the sluice room I temporarily joined an assemblage of new practices and attempted some of the everyday work of my colleagues. I handled new materials, began to systematically move my body in different ways according to new actors and routines as I unloaded the trolley and sorted its contents into different bins, sinks and pottles, washed and stacked instruments, and then waited for a new set to arrive from theatre. My sluice room activities mediated different connections and importantly, my involvement in the sluice room produced currency for me with my colleagues. As a follow on from this, I gained access to other care practices of nursing staff, and thus, the field beyond my social worker sites of practice.

It was this 'behind the scenes' action and exposure to the diverse arrangements that enabled me to 'un-black box' or disassemble some of the abortion practices I had previously taken for granted (see Latour, 1999). For example, in my social work role, handling, reading and writing into patient files was an integral part of my work. Prior to this study I did not afford the patient file much attention – it was a common workplace object that I 'used'. However, I was able to break down some of the consolidated work with documentation by following reception

and administrative activities. Accordingly, I 'made up' files and sorted test results that would be inserted into these alongside other service documentation. I put away sets of files in the filing room once service users had departed the service and completed their participation in abortion networks within the clinic setting. I learnt how to order these files onto shelves according to the NHI number that feature in coloured stickers across the end of the file. Because I could follow this system, I could also retrieve files for service users who had come to Lyndhurst in the past and were revisiting the service. I began wondering about the practices in between the start and finish of care – not as these occurred in the counselling room, consultation room, or operating theatre, but how assemblages of abortion – its actors and practices - were both accounted for and enacted in texts.

Following multiple practices at multiple sites

ANT requires the researcher to trace webs of relations that connect different sites. In this way, by following actors, I was able to move from one site to the next within Lyndhurst. I followed actors' recommendations to undertake other observations or conversations. After my sluice room activities I was invited to observe multiple practices on 'the ward'. By following one of the nurses for the day, I was alerted to the practices of preparing for the day ahead where lights, heaters and a radio were switched on, medications were gathered and logged, and trolleys of sterile draping and instruments were prepared for theatre.

At other times, I followed other nurses in the process of admission and the preparation of service users for theatre, by pointing out bathrooms and assembling them with blue hospital gowns, hospital beds, and medications that preceded theatre. I followed nurses' practices as they monitored the recovery of service users post-procedure. On one occasion I helped bring service users cups of tea or coffee and toast, an activity I could do, while the nurses mobilised service users to the bathroom and to take short walks, and removed the luers that had been inserted into their arms pre-procedure. One of the nurses joked with me as I am delivering a pack of IUD's to the recovery area, "You've done everything here except put in IVs". While this was far from true, my presence in different spaces and as part of different practices was becoming more comfortable both for me and the staff I followed.

Though, at times my colleagues had seemed perplexed by my involvement in these activities, they also enrolled me into multiple sites and practices alongside key material actors by showing me and teaching me about who and what they worked with. For example, whilst I had seen an abortion procedure in theatre during my induction to the service as a new employee, I had opportunities to understand this set of practices in a more nuanced way. On

one occasion, a senior nurse stood beside me in the sluice room with a set of instruments simulating the abortion procedure as she explained what was used and how these worked. Her actions and use of the instruments appeared so mastered and I recall my surprise of later sitting alongside a doctor in theatre seeing a replica of this procedure I had initially seen enacted by the nurse. Following a range of actors enabled me to enter into different parts of the building, be exposed to other roles, conversations and activities and enter different network arrangements.

Participant observation

Participant observation is a dynamic method that affords the flexibility to approach complex and messy realities such as abortion (see Law, 2004). Like Wilson (2014) explains concerning her study of youth work and hip hop, participant observation is a method that allows the researcher to follow actors across sites of practice, so to unpack the contingent socio-material practices that could otherwise be simply 'black-boxed', ignored, or taken-for-granted. Actor-network theory avoids the *a priori* expectations in favour of mapping and following what occurs within the field (Latour, 2005). Like Wilson (2014) and Kerr (2010), my participation or immersion in the field was not just a matter of following or shadowing the action, but it was about becoming/being part of the networks.

As I mentioned earlier, in my role as a social worker at Lyndhurst I provided counselling services and conducted psychosocial assessments with women who were either considering abortion, or who were engaged in a trajectory through the service, and occasionally after an abortion. I understood and used some of the terminology and jargon of the field in my interactions with service users and colleagues. My part-time status, and the downtime that was part of my social work role when 'counselling' was optional,[17] enabled me to be involved in activities that I might not have had the opportunity to had I been engaged in full time social work practice, where my research practices may have competed more readily with the responsibilities of work.

Participating in connected abortion networks

My social work role mediated my attendance at staff meetings, engagement with workplace documents, movement throughout the building and extended sites of abortion provision. For example, I not only circulated within the spaces of Lyndhurst, but because of the shared practices of abortion provision across different sites, I had opportunities to visit providers in

[17] Chapter 4 describes the reconfiguration of the social work role as part of an account of dynamic nature of professional identity.

other New Zealand localities such as Level J (now Te Mahoe) in Wellington, Auckland Medical Aid Centre (AMAC), a private Auckland-based clinic and the public provider, and Epsom Day Unit, also in this locality. Staff in these settings showed me through the service and I was exposed to glimpses of different reception areas, counselling rooms, operating theatres and sluice room arrangements. I talked with staff, asked questions, and wrote down some of information about how work was assembled in these settings.

I attended several conferences, the Mifepristone in Australasia Conference in Wellington in 2009, and later I attended the New Zealand Abortion Providers Conference in Rotorua in 2012, where my entry to this 'closed' conference was mediated by my research and my involvement with abortion provision.[18] In these settings I confirmed some of my ideas and knowledge but also learnt a great deal more about abortion practices, for example, how medical abortion had made its way into New Zealand, and the legislative and logistical challenges that were part of this endeavour. As part of this, I was exposed to, for the first time, how unstable and mutable medical abortion practices can be. Within the arrangements of the conference, I watched lively exchanges as doctors argued and juxtaposed different sites of care (clinic or home), which pills should be used, in what dose, with what timing, and noted the variance of ideas around risk and effects of medical abortion.

Being part of abortion networks enabled me to enter other sets of relations outside those close to me. For example, I was able to negotiate access to 'pro-life' actors and met with counsellors and counselling materials such as books, pamphlets and rubber foetal models. I was invited to attend a 'pro-life meeting and screening of a movie, 'The Miracle of Life', and was approached afterwards to participate in informal discussion.

My embedding within the field, as somewhat of a hybrid, meant that I was at risk of overlooking the ordinary, and might grasp instead at the outer most aspects of abortion practices, the more sensational and the more unusual, and stitch these together as an accurate account. Coffey (1999) and other authors have noted that a researcher who is unable to stand back from the knowledge they have acquired may face analytic problems.

The 'following' or shadowing of actors - social and material (see Latour, 1987) - offered me a way to look and experience abortion networks in a different way than I had as a social worker. I was able to follow abortion controversies without taking sides, to focus on 'the action' and the actors involved in this action, and account for how different abortion controversies were

[18] Access to the Rotorua conference was by invitation or referral from a registered delegate. I made contact with the Clinical Manager at Lyndhurst who supported my access in this case.

generated and who and what was involved without the need to defend, evaluate or judge these multiple realities. For example, I was able to follow the network consolidations of service users, staff in abortion provision, and protestors concurrently with a focus on how these networks were assembled and enacted rather than pitting these connected groups against the other. Following a range of actors and practices meant that a multitude of leads were concurrently generated which reflected rich and diverse organisational contexts and practices. In order to follow these leads I needed to embrace the messy ways in which I might trace these. Conventional and orderly means of following the action did not work, and in order to get close to this action, I needed to embrace a messy methodological reality.

Mutable boundaries: Being part of the networks

As an actor-network approach is highly self-reflexive, the researcher inevitably participates and is implicated in the research as part of the network they follow and seek to describe. Star (1991) argues: "People inhabit many different domains at once … and the negotiation of identities, within and across groups, is an extraordinarily complex and delicate task. It's important not to presume either unity or single membership, either in the mingling of humans and non-humans or amongst humans." (p. 52). As an actor that was part of an abortion assemblage, I participated in multiple and overlapping actor-networks, the effects of which required juggling multiple and overlapping enactments of my identity (Barnacle and Mewburn, 2010).

Though I still conducted the roles and tasks of a social worker, my research activities reconfigured this professional identity, whereby I began to encounter my work worlds in new ways. The multiplicity of my own identity alongside that of others meant that the shifts between 'researcher' and 'social worker' became less defined. Moreover, I learned that I was neither social worker nor researcher, but rather a hybrid, configured of nuanced threads of many identities. For example, in a planning meeting at Lyndhurst about implementing a new medical abortion service, I was a delegate for social work interests of having the practices of counselling becoming a routine part of this new service while at the same time I held research literature I had gathered about medical abortion as part of my studies. The social work and research role informed the other and together they produced a hybrid identity and toolkit of information beyond what I would have acquired in my social work role alone. I made use of this assemblage to contribute to arguments about the inclusion of counselling, and because of the wider literature I understood medical abortion in a more nuanced way – such as the

medical terms and techniques I had read about. Moreover, within this meeting I listened, not merely as a staff member, but for how this could inform my research.

Another example of how my social work and research roles intersected is how my involvement in research practices changed how I engaged with service documentation. Instead of just 'writing up' my notes in the 'Pathway of Care', I noticed how overtime that spaces within the documents in which social work notes were written began to shrink. As a social worker, I questioned this reduction of space and how it came to be, as did my social work colleagues. Alongside this, as a researcher, I became interested in the effects of this reduction on professional identity and presence of social work as a network consolidation that sat on the margins of the medically-driven health services of abortion provision.

The mutable boundaries of my identity also emerged in my interactions with other actors. The residue of a historical schism between social work and medical staff extended to my research role where a staff member would be ostracised for engaging with me in a research capacity. Whilst I had many opportunities from Lyndhurst colleagues, I also faced some adversity. For example, there was an instance of a staff member saying to me in hushed tone "I'm sorry, but I can't be seen talking to you – she won't like me telling you things". For actors that held reduced social currency in the setting I was part of, it was sometimes difficult for these actors to openly engage in the research I sought to undertake or even appear to be doing so. As Coffey and Atkinson (1996) indicated, as a researcher (and practitioner for this matter), you cannot control how others perceive your participation.

These mutable boundaries also played out in interactions and interviews outside of Lyndhurst. I was called upon to give back in a reciprocal fashion where "'insider knowledge' was exchanged for the 'expertise'" of various actors (Epston, 2014, p. 107). Like Law (2004) discusses in his notion of 'Method Assemblage', to bring something into presence is to make other things absent at the same time. In this way, in the midst of research-related interactions, at times my social work role was brought into presence and the research activities momentarily displaced in order to discuss elements of abortion provision.

Laypersons, medical practitioners, and actors who held perspectives about abortion at different ends of the continuum asked questions about abortion provision at Lyndhurst. For example, I spent some time part way through one of the interviews explaining the newly inserted practice of medical abortion to a participant in a medical setting and consequently, passed a request for training to a medical colleague. A further example concerned interactions with an actor from a 'pro-life' setting who was interested in the nature of counselling and the

relevant training and expertise that social work staff held. Inevitably, this blending of roles raised a dilemma concerning the point at which a boundary should be located and 'firmed up'. Because of the shifting nature of this aspect of the research journey, there were no ridgid means through which to address this issue. What I did, was to disclose the scope of information that I knew would be publically accessible and where this did not meet the need of the related actor, I sought to offer a contact or link of an actor or agency that might be able to extend this information further.

Packing the world into words

Latour (1999) argues that "we pack the world into words" through a series of translations or movements (p. 24). In this section I account for the translations and movements that ultimately resulted in the production of this thesis. I describe how data were generated and gathered, how this data was sorted, and the dynamic process through which a description was produced.

Generating data

Nimmo (2011) talks about how ANT sensibilities help to sensitise researchers to complex and multiple actors and assemblages that might otherwise have remained obscure. I was no exception to this. Like Mol's (2002) approach, I was interested in the day-to-day practices at Lyndhurst – the events and activities. What ANT required of me was that I consider both human and non-human actors, and be responsive to how activities and events were relationally assembled. For example, in this way, the patient file at Lyndhurst was not of interest merely for its content. Instead, we can see how this ensemble of documents not only provides a particular record of abortion provision, but how its words, lines, tick-boxes and spaces help shift various practices into documentation, or how it enrols other actors – such as service users, doctors, social workers - when they are required to feature within this document.

As Prior (2008) discusses, texts are active and are interesting for how they account for, translate and mediate the world. Thus, with ANT, as Lee and Hassard (1999) discuss, the generation of data does not involve "a passive collection of 'raw materials' silently awaiting the researcher's gift of intelligibility, form and voice" – rather data are a site of "active processing" (p. 399). Data are produced through the interactions between human and non-human actors and this collective work offers an enactment of reality.

Like other researchers, I followed processes of gaining ethics approval.[19] I talked with the wider team at Lyndhurst within existing workplace meetings, and introduced my research objectives and methods. This was met with neither great interest nor resistance among the staff I spoke with. I was not questioned concerning my motives or credibility for conducting this research. As a naïve inquirer, I anticipated that the research I was involved in might generate some interest and discussion of ideas. However, while I was always accommodated when I wished to communicate aspects of the research process, such as gaining informed consent from service users and staff, the discarding of information sheets on the coffee tables in the tearoom at Lyndhurst, for example, indicated to me that the research was primarily my interest rather than that of the collective of Lyndhurst staff.[20] For the most part, my initial entry to the field and research presence appeared uneventful.

Data were generated from my involvement in the field, through various conversations, interviews, observations, and readings, and was not 'captured' but reconfigured through a variety of textual and other material devices that gave this form. My field notes were often assembled in emails when I was able to sit down at a computer at Lyndhurst and email myself an account of what I had observed as soon as practicable after this event. At other times I spoke into a digital recorder as I drove home from work where it was useful to record events, thoughts, reflections, and tasks immediately after leaving the work environment that I could later transcribe at home and add further thoughts and reflections. I also wrote in notebooks, and in the midst of competing demands, I would write on a meeting agenda in my diary, or if caught 'on the fly', I would note a word or two on the back of my hand. I did not roam the field notebook in hand, but adapted to the changing configurations of the field. My aim was to record as much as I could, as detailed as possible, as close to the event as I could manage. The recorders, notebooks, computers, back of hands, and diaries that I used were mediators that helped generate tangible and transportable data.

Whilst I did not conceal my research activities at Lyndhurst, I sought to be unobtrusive in my research practices. I sought to avoid an assemblage of scrutiny and voyeurism by watching and recording events in arrangements where either my behaviour would appear odd, or where my doing so might be insensitive, such as in the operating theatre or doctors consultations. I

[19] I gained ethical approval from the Health and Disability Ethics Committee and the University of Canterbury Human Ethics Committee. A locality assessment enabled me to research the site of Lyndhurst as part of the Women's Health Division of the CDHB.

[20] The exception to this was from several social work staff within and outside of the setting who maintained interest in the project throughout is duration including the writing up of this thesis.

selected moments that seemed appropriate to clarify with staff something I had encountered at an earlier time. In these instances, I often premised these conversations with staff with "So, thinking about this for my research…." or similar in order to help make my intentions overt to others.

From Lyndhurst and beyond I also acquired additional texts and artefacts. I obtained service pamphlets and documentation from Lyndhurst, and at the clinic gate I acquired various protestor pamphlets. Beyond this setting, I was given a small plastic foetal model from a pregnancy counselling service. An anonymous recording and accompanying literature of 'pro-life' material appeared in my mailbox at home.[21] Further, because of my linking in with 'pro-life' community settings, I was invited to a screening of 'the Miracle of Life' film, was encouraged to peruse material, and was given handouts and a book to take with me.[22]

I became sensitive to other material devices that accompanied me as part of the data gathering process. In the interviews that I conducted with other actors in their offices, homes, or cafes, I learnt that the placement of a recording device or the presence of a notepad and pen could hinder the ease with which the interview took place. There were times when I pushed the recorder to the side or discarded my notepad in order to build rapport and cultivate a sense of safety for participants. An example of how this was enacted is illustrated in my post-interview notes below:

> *The participant directed me to the kitchen table with the coffee she has made. We start the interview…The participant is uncomfortable, she keeps looking at the recording device. Her responses offer just one or two words. While I might have a relationship at work with the participant, in this intimate setting of her home, things changed. I have come with a tape recorder and questions – the dynamics have changed. The interview is not going well. How to fix this?*
>
> *I had placed the recorder on the table between us but off to the side…I push the recorder away further amongst the table ornaments and explain again but more fully that while I am recording our conversation, she would be able to check though the*

[21] I held a degree of anxiety concerning my exposure as part of abortion provision and the possible repercussions of this. However, these fears were unfounded.

[22] Whilst I was aware that I was attending the screening of this movie, I was unaware until my arrival that this occurred within an Annual General Meeting of a key 'pro-life' organisation in which there was time dedicated to discussing and building the dialogue in which to confront 'abortion apologetics'. At the close of this meeting, I did not experience any hostility, but rather the enthusiastic offering of information, arguments and resources. However, this was certainly one of my less comfortable fieldwork encounters as a member of abortion provision, a service that this group actively opposed.

transcript of what we discussed…[and]…had the opportunity to amend the transcript. This made a significant impact on the interview – The participant no longer glanced towards the tape recorder and her responses were more full and descriptive.

I notice later when I'm transcribing the tape that my voice changes at this time to a more casual tone, and I begin to talk more informally and use slang – I even develop more of a 'kiwi' drawl.

Through the activities of research I was made sensitive to the assemblage that constitutes an interview and the ways in which I modify and tinker with this assemblage in order to both progress the interview and put the participant at ease. Further to the adjustment of research devices, such as the recorder and notepads, I used my voice and body position to more readily reflect the participant context that I entered into. I spoke more casually or more formally, used lay-language and colloquialisms or conversely engaged technical jargon. I relaxed in my seat or sat more upright, accepted cups of tea or coffee or conversely conducted myself with more formality, depending on who I was interviewing and my gauge of their comfort.

Overall, I conducted 52 interviews and a multitude of observations during the course of my fieldwork. I can account for some of these observations in an orderly way. For example, I observed three surgical procedures in theatre, followed two different nurses in setting up for the day, spent three mornings in the sluice room, shadowed reception staff on three occasions. However, tallying the many observations of the field does not account for this messy research reality. For example, whilst I spent three mornings in the sluice room washing instruments, I entered this space a great number of times over the duration of my fieldwork. Likewise, along with the observations of reception work, I 'helped out' by sorting results and filing medical records and talked informally with staff about aspects of this work. It was not possible to tally each observation, time spent, and the purpose of these encounters. To account for the routine encounters of my working day and the other experiences I was privy to, I wrote regular memos of the activities I was part of and my thoughts and questions concerning these. I collated these memos and intermittently overlaid these with further thoughts and ideas to help synthesize the data I were exposed to. Discussing these activities, thoughts, and ideas with my academic supervisors helped develop my responsiveness to this material.

Translating the field into words

As noted earlier in this chapter and in Chapter 1, an ANT-ish approach does not seek to impose frameworks to the field of inquiry. However, it is not easy to avoid applying theoretical

explanations or privileging the agency of human actors. Guided by the virtues of slow research and being alert to ethnographic surprises, what I have attempted to produce and provide is a descriptive account of abortion rather than an explanation.

In researching what Law (2004) might refer to as a 'messy world', I sought to 'know' this world by being responsive to how the actors themselves configured abortion. By relying on the 'world building' capacities of the actors, I wanted to ensure that the analytical techniques I employed did not unduly tidy up abortion for the sake of order. From the initial analysis and insights from field notes, interview data, documents and supervision dialogue, it was apparent that 'abortion' was neither an orderly phenomenon to investigate, nor was the data orderly to analyse.

I encountered ethnographic data collection and analysis as dynamic processes.[23] Rather than occurring in a discrete fashion, these were lively generative entanglements where the emergence of data interdependently mingled with building of conceptual ideas. Like the genre of detective work, I followed a network of informants, traced connections, gathered data, linked data together, revisited data, referenced data against further data, and assembled all of this in an account to make a descriptive case for a complex, multifaceted, kaleidoscopic abortion reality.

The data had already been on a journey of translation prior to the analysis phase. For example, the interview dialogue had been recorded, transported, played, heard and reassembled via transcribing into a typed document on a computer and stabilised in paper form. Within the analytic process, I sought to retain the authenticity of original encounters when I revisited these in text, while at the same time, I disassembled and reassembled the data and stabilized this into another textual end product. Given that texts are produced though the collective work between human and non-human actors (Latour, 1999), I became conscious about the need to avoid a human-centred approach when relying on transcripts of interviews (and other items like pamphlets that featured as data for this study) (Nimmo, 2011).

The organization and analysis of the data from interviews, fieldwork, and various documents and artefacts I had accumulated was on-going, time consuming, cumbersome and often overwhelming. Indeed, the accruing of voluminous data from qualitative research processes is a common, if not daunting, experience (Liamputtong, 2009; Spencer, Ritchie, & O'Connor, 2003). After a persistent but unsuccessful attempt to analyse the data using a computer

[23] Data analysis is an inherent part of the qualitative research process from inception to completion (Liamputtong, 2009).

program, NVIVO8, I revisited the process of analysis manually. My experience with NVIVO was that data were 'tucked away' within the various categories I created. I sought to engage with the data more closely by seeing, holding, and physically sorting the data that I had acquired. The unbound methods of cutting and sorting data and writing and rewriting drafts of chapters, then cutting and sorting again, helped me to explore the different ways in which the various actors involved assembled abortion.

I found that informal writing was a significant part of developing analysis and assisted making tangible the certain themes, issues, and ideas that emerged from the data. I wrote analytic memos, streams of consciousness, and structured writing that often provided the impetus for discussion within supervision meetings. I also kept my own documentation. As more data were gathered, some ideas from the data re-presented a number of times such as 'disclosure', disruption, or 'decision'. In using an ANT sensibility, I did not follow an analytic process through to explanation but relied on the mode of description to make my case.

Generating a description

As I have frequently noted, ANT is not an interpretative framework used to document, order, and explain. Therefore, there is no pretence that this is an objective account that analyses every aspect of abortion in Christchurch, New Zealand. Rather, it is a descriptive account of a messy world that tells a number of stories from a range of viewpoints about abortion. As such it connects with, but mostly differs from, existing accounts of abortion. This thesis then offers a "mere description" (Latour, 2005, p. 137) of abortion in Christchurch, New Zealand.[24]

Law (2012) suggests, that when we follow the actors, and look carefully, slowly and without assuming too much, "we will find the whole world folded into a field site or a practice" (p. 4). The sensibility of ANT emerges both out of the 'theory' and of the ethnographic fieldwork – in this case, from both ANT and abortion. It seeks to 'show' rather than 'tell' about how abortion is assembled. It trusts that actors know a great deal about the worlds they are part of and affords human and non-human actors the status of defining the worlds they occupy (Latour, 2005). Thus, it discards the need to distort this by adding a theory or frame through which to explain the work of actors in producing abortion assemblages.

With ANT, as Latour (2005) makes clear, it is not the task of the analyst to impose order on what the actors offer in the course of research. The description I provide in this thesis

[24] Certain types of experimental writing, particularly the presentation of unedited interview transcripts without analysis or theorising, are a way of "giving a voice" to those being studied in a way that was otherwise denied to them' (Murphy & Dingwall, 2003, p. 14).

attempts to allow the messy and multiple realties of abortion to be visible. "Reality" rather than being assembled once, 'dances' from one version into the other depending upon the actors and practice involved (see Cussins, 1998). There are times that these descriptions are dominated by the words of human actors as they describe their part in abortion networks.[25] Of course, non-human actors are not able to 'speak' for themselves, and I provide descriptions of them that are based on what has become visible and observable.[26] Like other doctoral students using ANT (see Kerr, 2010), I have grappled with the inevitability that the descriptions are provided by me as the researcher. Essentially, these descriptions are my account of shifting assemblages of abortion.

In the practices of writing, this imperative of "mere description" (Latour, 2005, p. 137) proved challenging to do and I grappled with the task. For example, in my early writing I began to talk about sluice room activities as 'dirty work', drawing from the work of Everett Hughes (1962) and some of the more recent research literature that considers aspects of abortion in this way (for example, Chiapetta-Swanson, 2005; McMurray and Ward, 2014; Simmonds, 1996). Had I persisted in using 'dirty work' to frame the activities of the sluice room, then inevitably, it is likely that 'dirty work' is what I would have found, and how my analysis and writing would be shaped. And not because this 'dirty work' emerged from the data necessarily, but by employing a frame, I would have already decided to order it in this way. In this way, I would have leapt straight from a frame to the data and data to a frame without accounting for what might have occurred in the twists and bends in between (Latour, 2005). To ascertain what the actors themselves determined about the work of the sluice room I had to reject the frame of 'dirty work', and instead engage in the process of following to map how the actors assembled the activities of the sluice room on their own terms. I had to learn to provide detailed descriptions, and allow these descriptions to generate their own explanations – without me "adding" anything more (Kerr, 2010).

[25] Within this thesis I draw attention to various human actors. I have identified the contributions of those who participated in interviews by interview number rather than assigning a name. Moreover, I have elected to refer generally to roles, rather than offering specificities. The same is true for peripheral actors and organisations. The reasons for this are largely related to the rather small world of abortion networks where privacy is valued. Many of the participants in the research held hybrid identities where they linked into multiple parts of the assemblage of abortion. I did not want the reader to build an identity of a particular participant via the repetition of a pseudonym across multiple sites.

[26] I have elected to talk generally about the actors I follow. To be explicit about who and which organisations I linked with would risk breaching the privacy of these participants in the relatively small network of abortion in Christchurch.

Reflexivity

Writing is a key site through which 'the field' is reproduced. As Latour (2005) states "Textual accounts are the social scientist's laboratory" (p. 127). In this view, the writer undertakes a process of purposeful experimentation in order to reproduce encounters from the field. Thus, whist I describe the tinkering of others in this thesis and in producing this account, I have tinkered as well.[27] Like Wilson (2015), I have engaged the use of the hyphen where, much like the hyphen in actor-network theory, I have used this to demonstrate the co-creation of any actor or reality. This is a particularly evident in Chapter 5 where I describe different versions of the body – the pregnant-body, the textual-body, and the patient-body.

Concurrent practices of textual generation and erasure are necessary to yield an end product. In the generation, reduction, and filtering of data, inevitably a dilemma arises concerning what is erased. Decisions must be made about which stories to tell and how to tell these (van Maanen, 2011). As Law (2004) indicates, the assembling of a representation brings some aspects of the social into presence, whilst, inevitably other parts of social worlds are made absent or othered at the same time. Similarly, Law and Singleton (2013, 495) discuss this as a mode of intervention – of how power may be present and distributed by acting *in* (as part of) and *on* the world.

> When we describe a scene we make choices—mostly implicit—about what we're going to describe and what we're going to leave out. About which actors to follow and which to leave be. About what to treat as powerful…and what to ignore. And those choices partly depend on our own agendas, political, theoretical, personal. And they partly depend on how we're being led by our ethnography, on what people are saying….

Thus, I make clear some of my choices. In this thesis, there is no dedicated attention to the decision-making of women concerning their pregnancy outcome and associated themes of 'choice' and 'agency'. There is a body of literature that attends in detail to these specific aspects of abortion (for example, see Allanson, 2007a; Furedi, 1996; Hadley, 1997; Kukla, 2005;

[27] I was not the only person involved in the landscape of the research – my supervisors were also part of this. Supervision sessions that reflected on the sluice room, or counselling, for example, were key to illuminating new ways of being sensitive to the heterogeneity of these arrangements. Moreover, one of my supervisors, fairly new to ANT sensibilities, began to use the attention to 'things' that ANT affords in her other work: She began a photographic project with a group of postgraduate students that documented some of the human and non-human actors involved in producing what might be consolidated as a 'social work identity'.

Lunneborg, 1992; Surman, 2001). Rather than replicate this material, ANT has offered me a different means though which to consider 'decision-making' in abortion networks and the process of translation that mediates movement from one part of an abortion trajectory to the next – Chapter 7, in particular, attends to this effort.

Similarly, the reader may note the absence of conventional attention to gender within this thesis. A specific feminist lens has not been employed.[28] Moreover the imposition of such theoretical frameworks or boundaries would be very un-ANT like. In contrast to adopting analytical frameworks, such as those often referred to as feminist, Law (1991) argues that we should seek to 'unlearn' the conventional "order of things" (p. 17). Law (1991) suggests that "No one, no thing, no class, no gender, can 'have power" unless a set of relations is constituted and held in place: a set of relations that distinguishes between this and that" (p. 18).

So this ANT-inflected research does not seek to reduce the social by looking for "class, or state power, or gender", for example, as a framework or theoretical base in which to explain the world (Law and Singleton, 2013, p. 496). Instead, using ANT sensibilities, I look for the unexpected forms of power and how these work (see Law & Singleton, 2013: 496). By not relying on these structures to guide analysis, other lines of inquiry may be opened up. As Law and Singleton (2013) explain, ANT sensibility may still reveal these conventional types of power relationships, but it is also interested in "ethnographic surprises", and therefore tries to illuminate other forms of power that may be at play (p. 500).

For me, very much in the way that Casper (1997) describes, one of the key learnings of this research was that who, how, and what I was in the assemblage I sought to explore inevitably has effects on the research process and production of this thesis: as a woman, later as a pregnant woman, and eventually as a mother; as a novice social science researcher seeking to explore further the controversial abortion work that I had selected to be involved in; as a social worker on the margins of the core medically-focused work of abortion provision; and later, on the margins in a different way, as a fixed-term academic. Similar to Casper (1997, 241), "I could not "turn off" my politics once I entered the field" and to claim that I was sanitised into 'neutrality' would be naïve let alone counter to the ANT sensibility that takes seriously the 'making' of any given reality. Concurrently, my engagement in ANT concepts, strategies and mapping processes of the research inevitably shaped "where I ended up" (Casper, 1997, p. 234). In this way, whilst I certainly started this research with ideas of what 'abortion politics',

[28] As Quinlan (2012) has noted "[t]o refer to feminist scholarship as a unified tradition of thought and practise is [therefore] a simplification of its diverse history" (p. 2).

'women', social workers', or 'abortion provision' looked like, because of my engagement in ANT methods, I learnt new ways of 'seeing' abortion provision that turned to how versions of abortion were assembled and reassembled rather than abortion being something readymade that I might have a perspective on. Thus, I sought to embrace ambiguity and, in the writing of this thesis, to appreciate that mutable, messy, and multiple realities coexist.

Related to 'following the actors', there were leads that I chose not to take up. For example, Lyndhurst acts as a gateway service for some second trimester abortion that occur at Christchurch Women's Hospital. While I was exposed to some of these practices at Lyndhurst, I did not attempt to follow these beyond 'the gate'. In this way, I 'cut the network', in order to focus on service provision at Lyndhurst (Strathern, 1996). Like Law (2004) indicates, any given account can only be a partial description.

As Latour (2010) and others discuss, even the purest scientists are 'makers' of their 'facts'. This thesis does not offer 'truth' from a distance. With ANT the researcher is part of the landscape and research practices are highly reflexive (Lee and Hassard, 1999). Like Passoth and Rowland (2013), I contended with how much reflexivity was enough. I posed many questions to myself: Did I sufficiently show the circumstances of production in the account I produced? Was I present, or did I overstep the invisible boundary of reflexivity? Did I need to get out of my own account and let the data speak further for itself? (Passoth and Rowland, 2013). Ultimately, I have not sought to remove myself from the network and present an unjustifiably objective and mythical text. I seek to reveal 'the maker' and do so in particular to make clear my involvement in the field. I have sought to strike a balance between holding my cards close and laying the deck on the table towards some point of stability.

The term 'account' is used in the title of the thesis to express the assemblage of data analysis, reflections, observations, insights and conceptualisations that comprise this text. In this account, I am located as an actor, and a professional insider of Lyndhurst, the primary setting of exploration. Similar to the notion of 'account' offered by Radley and Billig (1996), I offer a series of organised descriptions of events and activities where I have engaged various 'rhetorical devices', in this case, ANT conceptual tools, as a means to produce a story, or rather a patchwork of stories. With this in mind, I do not offer generalisations about abortion nor have I sought to be representative about abortion concerns. The descriptive text provided does not attest to 'the truth' about abortion but is a capturing of moments and multiplicities - of how abortion was shaped and reshaped locally and relationally between human and non-human actors.

Conclusion: Exiting the networks

Returning to the quote at the beginning of this chapter, "We start in the middle of things…Action had already started; it will continue when we are no longer around" (Latour, 2005, p. 123). In this way, the exit or end of the research is somewhat arbitrary.[29] There is no end as such but just a decision that what has been completed is enough. I could have chosen to remain in the field and perhaps continue fieldwork, yet, emotionally and practically, I decided to stop. There was no point of saturation.[30] As far as the field is concerned, there are always aspects of abortion that are changing, and networks will continue to evolve regardless of whatever endpoint is established. There are always more associations.[31]

The strengths of ANT presented difficulties for me as an emerging researcher – with no clearly defined boundaries, start and finish point, and descriptions of ever increasing numbers of actors and networks, I found myself overwhelmed at times.

> *In some ways the worker/researcher roles are now inseparable and of course they are influenced by who I am and who I am becoming as a person. Things I am involved in with work and the discussions I have with colleagues have changed significantly because of my course of study. My research role has also influenced how I practice as a social worker. I was already part of the field before starting the project, re-entered the field with a hybrid identity and now I feel like I'm a mobile assemblage of ever*

[29] Exiting the field opened up space for further analysis and the writing up of the research to take place. I left my position at Lyndhurst and the field in January 2011, a few weeks prior to the February 11 Christchurch Earthquake. Exiting the field involved a physical exit and my relocation from Lyndhurst to University and private spaces. At this point of departure from Lyndhurst I stepped sideways rather than exited abortion networks completely as I became a member of ALRANZ (Abortion Law Reform Association of New Zealand) and joined the local branch of NCW (National Council of Women) as an ALRANZ delegate until I could no longer maintain this commitment.

[30] Law (2006) indicates, you stop when you have uncovered the mechanisms or strategies through which the practices and/or objects hold together. A Latourian variation on the point of cessation is offered in his droll dialogue of a PhD student and supervisor where the supervisor states that the student need merely "stop when you have written your 50,000 words or whatever is the format here, I always forget" (Latour, 2005, p. 148).

[31] For example, a very obvious reconfiguration of the abortion networks that I studied includes the change of site from an offsite service to one within the hospital following the Christchurch Earthquake, 2011. Further changes include social work services being based offsite, and a standardised referral form for GP's and the like referring prospective service users to abortion providers. All of these reshape the version of abortion that I was part of.

increasing information that moves from home, to Lyndhurst to Uni and back. I feel like all the hats I wear have been shoved in a blender.

The continual assembling, disassembling, reassembling of actors produces innumerable leads to follow (Latour, 2005). However, every research project must have limits and an endpoint. As Strathern (1996) notes, a problem with following and tracing networks is that these may be theoretically without limit. It is not possible to account for every action from every vantage point. From the duration I was engaged in the field and my employment, and the data I gathered and worked with, I produced a snapshot or 'fragment' (Strathern, 1991) of the events I was privy to.[32]

[32] Strathern (1991) notes fragments are parts of broader and more complex realities. She offers further that even a fragment under inspection will multiply with complexity.

Chapter Three: Articulating the Abortion-Related Pregnancy

Introduction

Abortion assemblages are steeped in controversy and disputes. The conventional controversy concerning the moral and legal status of abortion, along with the self-named 'pro-life' and 'pro-choice' movements, is not the focus of this chapter. Such a focus would demand a dichotomous ordering of perspectives, a focus on the formation of a common interest, or single will (Müller, 2015) of actors that align themselves with one perspective or the other. Such 'pro' and 'anti' perspectives on abortion exist – indeed they shape how abortion is talked about and enacted, or not. But, a focus on 'pro' and 'anti' perspectives could lead to naturalising a perspective *on* abortion – which implies that abortion is one thing and that there are different ways of viewing it.[33] The interpretive qualities of perspectives and the dichotomies they create leave little space for attending to the variants of abortion and the specificities that arise in practices. Abortion, I am arguing, does not need to be thought of in this way.

The core premise of this chapter is that abortion controversies are assembled rather than existing on their own in nature: they are affected by human and non-human actors and the practices that bring them into being and give them form. Indeed, the accounts from actors of this study and my accounts from the field spilled out of a dualistic confine, and have frequently resisted a dichotomous split. In this study, abortion exceeded this conventional mode of ordering and instead entailed slippages, backtracking, contradictions and conditions. Actors did not necessarily conform to one way that abortion might take form but *articulated* nuances of abortion through specific wording, materials, spaces, and practices. It is in being responsive to these specificities and how they assemble together to compose variants of abortion that the splitting and collapsing of abortion controversy into perspectives proves untenable.[34]

[33] Linking in with ANT as an ontological strategy means that an account of abortion describes how different abortion realities are enacted into being, rather than explain the different perspectives on abortion. To this effect, with ANT it is possible to reveal the realities behind interpretations (Mol, 2002).
[34] Mol (2002) and Law (2004), among others, argue against reducing 'reality' into singularity.

With ANT, controversies are approached in a certain way. Venturini (2010) states that controversies are "situations where actors disagree" (p. 261). ANT sensibilities allow me to describe the situations where actors cannot ignore each other, nor can they compromise – as is the case with the abortion debate where opposing actors fail to reach agreement. These contested spaces where actors (people and things) assemble together is where representations, both multiple and overlapping, are co-constructed (Venturini, 2012).

Similarly, Latour (2005) argues that following controversy is to do with following debates over agency. Agency involves mediated action, or the ways that actors are made to *do* something. But when we follow controversy, we can have a particular interest in what action is invoked, and how this action is legitimised or discredited by other actors within chains of mediation (Latour, 2010). The unfolding of controversies, then, involves being sensitive to the uncertainties, disputes, variants and overlapping ways in which controversies are assembled (Venturini, 2012). As a strategy to follow abortion controversy, I engage the notion of 'factish', developed by Latour (2010).

Fact, fetish, or factish

In what was to become a seminal book, Laboratory Life: The Social Construction of Scientific Facts (1979, re-released in 1986 with additional commentary), Bruno Latour and Steve Woolgar gave a detailed account of the everyday activities of scientists. As Garrety (2014, p.15) so eloquently notes:

> Latour and Woolgar highlighted the importance of material objects in the construction of scientific facts - rats, mice, machines, chemicals, traces of paper coming out of machines (raw data) and documents and drawings that were eventually transformed into journal articles. The latter were particularly prized, and much effort went into persuading readers that the claims in articles represented 'facts' about nature. The material objects deployed and constructed in the lab (graphs, tables of results, pictures) were key elements in this persuasion. As such, they were scientists' allies - things they could point to as 'proof' if anyone should dare question the validity of their claims.

Latour (2010) uses the vehicle of religion to continue his argument against the distinction that modernity makes between nature and society.[35] He gives the example of the Guineans on the West Coast of Africa and the visiting Portuguese disputing the 'truth' of either the handcrafted

[35] See Latour (1993; 1999).

idols or divine icons they each hold. Says Latour (2010), "We see one group covered with amulets scoffing at another group covered with amulets" (p. 5). The point Latour makes is that there is no difference between the groups concerning their practices of crafting or revering their objects, yet, they are at loggerheads concerning which object is real and which object has been made.

When actors lose sight of the process of fabrication (as is the case in the example from Latour above), then objects can acquire certain qualities or agency beyond the collective work through which they emerged. The object then becomes what Latour refers to as a fetish. It is the unwavering belief in certain fetishes that divide camps.

As I indicated above, I use Latour's (2010) notion of 'factish' as a strategy to follow abortion controversy in this thesis. 'Factish' is a neologistic term that amalgamates 'fact' and 'fetish'. The term 'factish' does not ask if an object "is real", or has conversely "been made", but fuses the 'fact' and 'fetish' *because* facts are not distinct from their creation. The consequent 'factish' interpretation of an object as 'fact', despite knowing the fact is constructed, does not make it any less real.

The factish, then, as I am applying it to abortion, is a tool that enables controversies to be followed and teased out by accounting for how 'facts' are assembled, how different actors might seek to overturn these, and through what chains of action a variant of abortion can be claimed to be 'true.' In this chapter, similar to Robert and Dufresne (2016) in their work on the politics of DNA in the criminal justice system, the concept of 'factish' provides a tool to "move from criticism to critique" and to "leave the fault-finding behind" (p. 129).

Rather than consider *what* abortion is, this chapter is concerned with *how* different articulations of 'abortion' come to be. I am able to achieve this by focusing on a set of reconfigurations of abortion that link in with what I will call, with some resignation, the "abortion-related pregnancy."[36]

[36] Pregnancy 'itself', and pregnancy to do with abortion, is highly ambiguous; there is no timeless, universal or natural 'pregnancy' (Duden, 1993). While the term 'foetus' has become an iconised, public and circulated representation of pregnancy since the 1980s (see Petchesky, 1987), there are disparities in knowledge claims concerning the visual, material and embodied presentations of pregnancy, gestational continuums, and esoteric manifestations of pregnancy that means that the term 'foetus' is rendered lacking. Moreover, in terms of following the pregnancy through different sites within abortion networks, the term 'foetus' imposes limitations on pregnancy as complex and multiple entities. At the outset of the project, it was not my intention to look outside of the 'foetus' or adopt a particular feminist drive to counter foetal dominance. The reason for doing so is to do with following the actors. In following these actors it is clear that the foetus acts as part of abortion networks, both in a material sense and conceptually, but it is one of many representations of pregnancy that was invoked within this

Articulation

Latour's (2010) writing about 'factish' reminds us that 'the pregnancy', that is part of abortion networks, does not assume a durable term that travels unchanged and unchallenged across sites. In this way, it is perhaps the ambiguity of the term 'abortion-related pregnancy' that is also its strength. The 'abortion-related pregnancy' is not a term that circulates abortion networks – I have created this ambiguous term because of the absence of a word that was fluid enough to travel across different sites, different 'pro' and 'anti' debates, across gestations, to and from pregnancies that are subjects and objects, pregnancies within and outside of the body and hold together these different accounts when the terminologies, practices and configurations of abortion will be shown to shift and change.

Mol, Moser and Pols (2010, p. 8-11) refer to the "problematic histories" of words that are coined for use in the public sphere in their work on care practices. These authors draw attention to the limitations of words, and the ways in which they have sought to adapt and tinker with words to write about the complex, verbal and non-verbal realities of care. Mol, Moser and Pols (2010) are not alone in focusing attention on words: Jutel (2006), for example, in her attention to the implications of the terms, 'miscarriage', 'abortion', and 'stillbirth', footnotes her consideration of which words to choose. As Jutel (2006) notes, the terms "baby" and "foetus", are problematic, either denoting personhood or autonomy (p. 426). In reading Jutel's (2006) account, the managing of the dilemma of language appears to emerge in the 'following' and use of the language of the legal, medical, and layperson 'worlds', that form the focus of her article.

Through these practices of talk we are alerted to differences. However, to account for an abortion-related pregnancy solely through the voice and that which arises verbally would risk missing some of "layers of differences" - the way that an object may change as it becomes affected by the elements it assembles with (Latour, 2004, p. 209). As Moser and Law (2003) discuss, a 'voice' need not be limited to that which is "verbal, textual or linguistic" (p. 4). In this vein, I engage the term 'articulation', primarily because it extends upon the latter. With 'articulation' it is *not* the voice alone nor the verbal exchange that need be privileged, rather

project. Moreover, the 'foetus' is less dominant within the clinic walls. Like Gerber (2002), who used the term "products of conception" as an alternative to "foetus" in her study of the ambiguity of early pregnancy, I wish to afford space for multiple accounts of abortion-related pregnancy. Further, I have used the term 'abortion-related pregnancy' to afford some distance from 'naturalised' and debated contemporary constructs of pregnancy and abortion-related terminology, including, but not limited to "embryo", "foetus", "baby", or "products of conception". This distance enabled me to listen more closely to how and when 'pregnancy' is referred to, how it is accounted for within abortion networks in specific sites and contexts, and reflect upon the implications of varying terms as they arose.

the broader properties of articulation that may progressively reveal "layers of differences" that I have referred to above.

Articulation includes 'wording' and the words that are cultivated in and through the practices that actors enter into (Mol, 2008; Mol, 2013). Moreover, articulation extends to the non-verbal, to the material, to imagery, to technological arrangements that will be shown to 'speak' of the abortion-related pregnancy. Like Latour (2004) argues, the term articulation is advantageous due to "its ability to take on board the *artificial and material* components" that in the case of the abortion-related pregnancy, help give it form (p. 210). Articulating 'the' abortion-related pregnancy enriches, or gives a voice to what can only be diluted by attending solely to a verbal and human account. Moreover, by concurrently drawing on Latour's (2010) work, the factish offers a tool for following the controversies that are articulated by the diverse actors that make up the networks and practices of abortion (Banks, 1999).

The terms, articulations and wording to 'speak' of an abortion-related pregnancy are described first in this chapter. The process of following reveals an absence of stable, shared and representative terminology about abortion-related pregnancy; this is evident in the different ways actors and co-existing actor-networks seek to articulate what the abortion-related pregnancy is. In contrast, a lively kaleidoscope of terminologies exists as wording is claimed and disputed between and within different actors and their collectives.

Secondly, we enter into the setting of abortion provision, where different terminologies to some extent can be traced to tasks and practices assigned to specific groups. However, this proves to be a fragile and an incomplete way of ordering a messy dynamic plethora of terms. Wording changes because the abortion-related pregnancy is not stable – it too shifts and changes, is assembled, disassembled, and reassembled – as wholes and parts. Accordingly, the abortion-related pregnancy is articulated differently by diverse actors when it is located within the body, in the sluice room following an abortion procedure, or if the 'products of conception' are taken home by the service user and mobilised out of the clinic and into private spaces.

As Banks (1999) states, "The status of the factish is all about the associations between humans and nonhumans and refuses the disabling opposition subject and object, [...] internal belief and external world" (p.2). Following this notion, finally, and still focusing on the factish, this chapter identifies foetal models in a community counselling setting, and protestor pamphlets that assemble at the gate of Lyndhurst, as mediators to negotiate certainty and 'truth' about the abortion-related pregnancy. I will show how specific actors were called on to articulate the

abortion-related pregnancy and make these claims durable. For example, when pregnancy is hidden within the body, artefacts and technologies are deployed to 'stand in' and 'speak' in a way that works to erase the ambiguity of embodied pregnancy and legitimise an 'out-there' claim about abortion-related pregnancy by making the pregnancy visible and tangible.[37] In this way, these objects are revealed to become other than themselves.

Articulation: 'Wording'

For some time in the course of this research, I found myself thinking that there was a lack of language to articulate abortion, that abortion was an ineffable entity whose descriptive form alluded my grasp. What I came to see was that there was in fact a lively generation of words, many words that did not filter into a common vocabulary. Moreover, this rich array of terms was not contained to merely one site. Indeed, there was an absence of stable, shared and representative words to talk about abortion that was evident in the different ways actors sought to articulate what the abortion-related pregnancy was. Accordingly, a kaleidoscope of terminologies came into presence.

Pols (2005) argues that 'talk' is a performative activity that does not necessarily represent the world but *makes* the world. The technique of 'wording' (Mol, 2013) is useful here as a means to account for the performative activity that Pols (2005) refers to, and for the production of divergent articulations of the abortion-related pregnancy that emerged from the field.

The term 'wording' comes from a key note lecture by Annemarie Mol titled: 'Feeling, wording, eating. On cultivating bodies' (Mol, 2013). Wording, as Mol determines, is a cultivation technique, a way of articulating or representing the world (Mol, 2013). As Mol argues in this lecture, there is no such thing as 'nature', there is no natural category of the body or emotion that exists in its own right, as singular, or as universally known.

Haraway (1991) offers a similar argument in her attention to the problematic category of 'woman' in Cyborg Manifesto where 'naming', like the use of a noun to identify an object or being, at the same time makes available and excludes what ultimately does not exist 'in nature'. Likewise, in this thesis, there is no natural category of 'pregnancy' in the assemblage of abortion. Instead of 'nature', as Mol argues, there is only cultivation – she is referring here to the means through which different versions of the body are produced (Mol, 2013). For

[37] This follows Law (2004) and his concept of 'out-thereness', indicating the notion of a singularity, an outside reality beyond ourselves.

example, different bodily practices cultivate divergent representations of the word 'feeling' - eating, physical violence, medical conditions, yoga, all may generate what might be referred to as 'feeling', but each example involves very different arrangements and practices (Mol, 2013).

As I have adapted Mol's ideas to this thesis, 'wording' offers a means to trace the production of terms that represent the abortion-related pregnancy. By adopting the technique of wording, we can become attuned to how versions of the abortion-related pregnancy are locally articulated, produced, generated, and cultivated in different arrangements and sets of practices. Moreover, this offers a means to follow wording disputes and controversies, some of which are presented by a service user in the interview excerpt below:

> I7: ...the nurse was like, "would you like to keep your pulverised foetus", and I was like, oh wow, I hadn't really thought of that. No, she didn't say that; I can't remember what she called it.
>
> Letitia: She might have said something like pregnancy tissue?
>
> I7: Yes! That's what she said. To me that was just like, what? That could just be like the lining of my uterus. I guess that's what it is. But to me it sounds like sidestepping the issue a little bit. "Pregnancy tissue", like, that's exactly what it is, but that was my problem, I was calling it baby right from the beginning and the doctor was like, "it's a foetus, not a baby" but I couldn't get it out of my head, to me it was a baby...I think they said it to try and make me feel better, like, not a put down, and I think that foetus was the terminology used by everyone else and I thought, oh my God, I've got to be careful, I keep calling it a baby. Which is great, it's kind of more neutral territory I think. I guess there's less blame attached, well not blame, I guess it's a little bit more emotive saying baby isn't it? So, I totally understand why that terminology's there but I always have a little bit of a laugh at "pregnancy tissue" it just seemed a bit more disconnected or something. Distant from what it actually was, but I guess at that stage if you've mushed something up, and there's nothing whole there anymore anyway.
>
> Letitia: What was it to you then? What would you have called it?
>
> I7: I don't know, I actually don't know. Well maybe just say foetus, I don't know. Maybe for most people it would be like it's not that anymore, you've just mushed it up, you can't keep on calling it foetus, but to me I guess if that's the terminology that's being used, maybe it could just continue...Maybe if a person had gone through

> all that and is thinking about it like a baby then I wonder what it would mean to them to have someone say "do you want to keep your cup of pregnancy tissue", it seems a little weird and dissociative... As far as language goes, none of it offended me, but I don't know how you find the right terminology, the whole area is such an emotive area, you're always going to muck it up for someone...
>
> (Interview 7)

In the excerpt from Interview 7, the woman grapples with the abortion-related pregnancy - what words to use, how to feel, how to engage with it. From her account, we are alerted to a number of terms; a "baby", "foetus", "pulverised foetus" and a "something" that changes and becomes something else once it comes to be "mushed…up", "pregnancy tissue", and "the lining of my uterus". Other actors that are signposted, the doctor, the nurse – call it different things. The wording of different actors alludes to specific sites and practices – the doctor's surgery, Lyndhurst, and the women's private space - all of which invoke different abortion-related pregnancy configurations.

The abortion-related pregnancy has material form, yet, wording is unstable, *because* the abortion-related pregnancy changes form. By tracing wording, the multiplicity of the abortion-related pregnancy is revealed: we can see that human and non-human actors have become inseparable within abortion assemblages, "partly blurring and partly re-instituting the boundaries between humans and technology…" (Muller, 2015, p.34). In the relational work between human and non-human actors, wording generates new versions of the abortion-related pregnancy.

Thus, in the Interview excerpt, the abortion-related pregnancy might start out as a "baby" or a "foetus", but once it is transformed by the assemblage of actors that make up the abortion procedure, the words engaged at one point are unable to travel with the changing substance of the pregnancy, when "there's nothing whole there anymore". The posited post-procedure wording of 'pregnancy tissue' is inadequate, it misses the mark. The wording in its inability to get close to this entity, is "weird" (Interview 7).

The cultivation of multiple words through different practice arrangements, shift the proximity of the abortion-related pregnancy to bring it 'close' or 'push it away' – both are articulated as problematic. Words have the effects of being more or less "emotive" or "neutral", with more or less "blame attached" (Interview 7). Words, then, come with attachments to feelings, to sensitivities. However, in what way words resonate or not with any given actor cannot be

predetermined. As the actor above reflects, "I don't know how you find the right terminology…you're always going to muck it up for someone" (Interview 7).

An Entity of Many Names

At Lyndhurst, the interface between Lyndhurst staff and the service user presents a certain set of site-led terminologies, specifically, 'pregnancy tissue' and 'products of conception'. However, wording within Lyndhurst, such as the 'products of conception' or 'pregnancy tissue' may be unfamiliar, or of ill-fit for service users. Indeed, at times service users resisted clinical configurations of an abortion-related pregnancy when these words did not translate onto the worlds of these service users whose expertise of abortion is cultivated through different means. Because service users engage in different practices than those that staff do at Lyndhurst, their wording is contingent on the sets of practices from which they arise.[38] The service user below speaks to this:

> I33: I couldn't think of a word to refer to what they [Lyndhurst staff] call 'the products of conception', which really pissed me off, the only thing I could think to call it was 'remains'. And the nurses in there didn't like me to call it that, they said, "we call it the products of conception". And it was like, right, but I'm calling it 'remains'. And that's really what it is - it's what remains from conception…that's the only thing I could think of because I wanted to take it away with me.
>
> Letitia: So you took the remains home?
>
> I33: Yeah, and they're up there, up the hill under a peach tree which has just had its blossom, it was just coming out. If you look up there you can see the very top one with the leaves and the very pink flowers has got a plum kind of growing right next to it…Because that's what I did with all the placentas from my children, I planted them under trees so I thought, what am I doing, I'm not doing anything differently here, this is this tiny wee thing. And this might gross you out but I wasn't afraid of it at all, I looked at it, and I poked around in it and you know, when it wouldn't come out of the plastic container I put my finger in and put it into the soil, I wanted it all to go into the soil. I just wanted to really get in touch with it – it, remains – I haven't thought of a better word…

[38] While the focus is not how words emerge in practices, a similar argument is made by Weitz et al (2004) where actors may claim alternate language concerning an abortion procedure.

(Interview 33)

The service user in the above excerpt has held the plastic container from Lyndhurst and has come in contact with the substances of the uterus, as Lyndhurst staff do in their work, but she engages with it in different ways and at a different site. At Lyndhurst staff have removed the pregnancy in an operating theatre with medical apparatus and gloved hands. Once this is transferred from the uterus and into the plastic container, for Lyndhurst staff, it becomes the 'products of conception'. For the service user, however, once transferred from the uterus to the container, the abortion-related pregnancy is worded differently. At her home, she removes "what remains from conception", with her finger, shifting another articulation, "this tiny wee thing" from the plastic container and into the soil, to "get in touch with it - it, remains" (Interview 33). Of the words she knows, "remains" fits best, and, she asserts, "that's what it really is" (Interview 33).

The words from one site are rejected, reworked, and replaced because of the arrangements of specific objects and practices and new words that are cultivated accordingly (Mol, 2013). Now, we can make links to Latour's (2010) factish concerning the tussle between words that represent the abortion-related pregnancy. The term offered by Lyndhurst staff in the excerpt above, "the products of conception", is refuted by the service user and this is replaced by the term "remains" (Interview 33). The agency of the clinic to determine how the abortion-related pregnancy is articulated only extends as far as there are actors to take this wording up and agree that this represents what the abortion-related pregnancy is. When this doesn't occur, an effect of this disparity is a proliferation concerning wording where, in different practices at different sites (such as when the remains are mobilised out of the clinic and into the soil), further words are produced that are sensitive to specific practices.

In the excerpt above there is a disparity between the terminology "out there" at Lyndhurst, and the terminology for the abortion related pregnancy "up there" under the peach tree. As prefaced in Chapters 1 and 2, Law (2004) discusses the concept of 'out-thereness' as denoting singularity, an outside reality beyond ourselves; the 'products of conception' at Lyndhurst is presented in such a way, as a term that articulates a singular reality. In contrast, the wording 'remains' could be an example of what Law (2004) might refer to this as 'in-hereness' – a reality made present that stands in for what is interdependently made absent, in this case, the wording that Lyndhurst employs. The absence of a singular term for the abortion-related pregnancy that is agreed upon and the inability for a particular term to travel across the

staff/service user interface makes us aware of the multiplicity of the abortion-related pregnancy, and the multiplicities that emerge through divergent practices.

Factish revisited

A 'factish' does not ask if an object "is real", or has conversely "been made", and thus it is useful to have in mind as we follow the way that the abortion-related pregnancy transforms and diversifies. New truths are formed and accordingly, *the* truth about what an abortion-related pregnancy *really* is, is uncertain. In this way, to draw from Latour (2010) and his notion of factish, abortion truths are assembled rather than discovered and inverted rather than disproved.

There is more than one truth and more than one way that terminology may emerge and apply for the actors concerned. Similar to Law and Singleton's (2005) study of alcoholic liver disease (ALD), different articulations of the abortion-related pregnancy do not fit particularly well together. For Law and Singleton (2005), mapping the trajectory of "typical patients" with alcoholic liver disease was problematic. Because of the different accounts of ALD that Law and Singleton (2005) received from the professionals they interviewed, and intersecting topics such as cirrhosis of the liver and alcohol abuse, ALD proved to be a "messy" object that eluded singularity. To link back to abortion, we can see that there are diverse articulations of the abortion-related pregnancy. Even from the same actor, variants are present, and these variants say quite different things.

A service user illustrates this point below:

> I38: I just kept calling it the egg, as if it was the bad egg. It was very hard for me to call it 'the baby'. In fact I do remember looking something up in the medical dictionary and flicking to a page on foetal development and looking at what stage the foetus would have been at and getting a shock as it had more organs than I had expected at that stage. I think sometimes you get shown this really miniature picture but you can't actually see with that but there is a subtle resemblance, the spinal column, the heart, so I didn't expect it to be as developed as that so I just really called it the egg. I know it's a fertilised egg. I spoke afterwards to a friend who is a doctor and she kept saying to me it was just a bundle of cells and that was quite helpful. Looking at it too, it's not exactly accurate either.
>
> (Interview 38)

The service user above refers to an "egg" and employs a metaphor, "the bad egg" to articulate her version of the abortion-related pregnancy. This metaphor prevails for this service user as it juxtaposes a second reality; the page on foetal development provided from a medical dictionary with the detail of the foetus including its organs, spinal column and heart – details not afforded by the small pictures the service user refers to. A third reality is presented, "a bundle of cells", a version of the abortion-related pregnancy offered by a friend, a doctor (Interview 38). Further, the service user offers a fourth reality, "I know it's a *fertilised* egg" (Interview 38 – emphasis added). And a fifth reality, a reality that was very hard, "the baby" (Interview 38). In this excerpt, the abortion-related pregnancy is all of these: the egg, the bad egg, the baby, the foetus, the bundle of cells, and the fertilised egg. They are all an articulation of the abortion-related pregnancy.

The service user in the quote above considers that the term "bundle of cells" that was presented to her was "helpful", but, she says, "it's not exactly accurate either" (Interview 38). In this way, a term may be helpful, but it need not be exactly accurate. The images in the medical dictionary are sought out and viewed as accurate. Yet, the metaphor of an egg takes precedence. Accuracy, then, is on shaky ground and the scientific 'fact' of the medical text is vulnerable to replacement by more intimately crafted arrangements (Latour, 2010; Star, 2010)[39]. Like Latour (2004) argues, accuracies may have their limitations, unlike the open-endedness of articulation.

Articulation in Abortion Provision

Within medically dominated spheres, such as Lyndhurst or referring medical settings, wording inevitably tends to fall within clinical, technical and biomedical parameters that fit with a predominantly medical model of care. Staff at Lyndhurst work together day after day and there needs to be some agreement about how to talk about the practices they participate in. Because language is incomplete to stand in for what words represent, inevitably language is standardized in order to move on with work, tasks and lives (Star and Lampland, 2009). Yet,

[39] Star (2010) in unpacking boundary objects gives an example of a study she came across on the human brain where the map for doing this had emerged from the mapping of the brain of a primate – quite different objects. Star (2010) notes that the article was successful, and upon pondering why, concludes that "the map did not need to be accurate to be useful" (p. 608). The map was useful as a communication device that whilst ill-structured/sketchy in common use, was useful to talk about across the worlds of clinical and of basic research (Star, 2010).

wording remains varied, even under an abortion-related pregnancy 'umbrella' of clinical articulations.

> I16: …in my mind I'm quite clear that it's still only an embryo, not actually a foetus or an infant at this stage, and I think that's something that I'm quite strong about …because some [service users] will say, "oh, I want to keep my baby", and I say, "well, I hope you understand you're quite entitled to take home the "products of conception". But a lot of the other ones [Lyndhurst staff] say "pregnancy tissue". I always say products of conception, because I say to them [service users] "what you are taking home is everything that's inside the uterus, so there's the lining of the uterus, there's the embryo, there's the placenta, the cord, the tissue, blood" and I say to them "it's only about that big [gestures] at this stage, so there's very rarely anything that you can identify"…So to me, it is an embryo, especially when the average age, or gestational age we're doing them at is between 7 and 11 weeks, averaging about 8 or 9 weeks gestation and when they come to us for their termination it's that big [gesture] so I think that's really something that I'm quite strong on, yeah, to make sure they understand that what we remove from the uterus in no way resembles what they saw or what they are flashing to in their mind of their children at home. It could do in future if they carried on a pregnancy and obviously the child would be similar to the other two at home but it's the decision they had to make…I think that you have to try and separate it out as much as you can that what we're doing and that the abortion which is the removal of the potential for a baby is not removing a baby, it's removing an embryo, and I think that that's an important point.
>
> (Interview 16)

In this set of pregnancy variations, there is a tendency towards logical, rational, and 'factual' ways of conceptualising the abortion-related pregnancy. Pre-procedure, the abortion-related pregnancy is called a pregnancy. The wording 'termination of pregnancy' refers to both the decision about the pregnancy outcome, that which has been decided upon, and the act of terminating the pregnancy as this involves a medical procedure in theatre. Post-procedure, staff at Lyndhurst tended to refer to the products of conception or pregnancy tissue, particularly when talking with those who enter clinical settings as service-users, and abbreviate this to POCs, or products or tissue or in numerical form as a certain number of

weeks and days, amongst themselves.[40] Distinctions may be made according to gestation where an embryo or foetus and foetal development are terms that circulate this setting.

It is clear, then, that even within the clinical version of the abortion-related pregnancy, and this shared set of articulations, variances arise. Even in the patient information that is circulated, wording is unstable. For example, The Patient Information book for surgical abortion refers to "Your Operation" on the cover and listed within the content page, the reader is party to wording variations, such as, "abortion", "the operation", "early abortion", and "termination of pregnancy" (Lyndhurst Hospital, 2006, p. 2). So despite the backdrop of the clinic, and its apparent certainties, the terminology used to reference the abortion-related pregnancy varies.

In the practices through which wording is cultivated, individual preferences determined which terms were used and the ways that these terms were abbreviated as part of 'in-house' communication amongst staff members. Moreover, in the intimate and informal exchanges between staff, terminology begins to fall away from the medical textbook and relate to the direct engagement with the abortion-related pregnancy that staff have as part of their work with abortion provision. The site of the sluice room illuminates this, and in the following fieldnotes, I encounter the abortion-related pregnancy by working alongside the nurse aid:

> *I ask about POCs (products of conception) and what happens if a woman wants to take these home. The nurse aid says they are marked with a red sticker and usually placed on the bench to be poured into a pottle and then this is placed into a paper bag. This happens with the next set. The nurse aid asks if I want to do this task and I agree even though I don't know that I do. She hands me a small clear plastic pottle with a separate screw-top lid, I take the oversized 'milkshake container' of product that has come from the operating theatre. The product is bloody and clotty. She tells me how to hold it so it won't spill. I hold it over the sink and hesitantly pour the POCs into the smaller pottle. None spills. "Give it a good tap" she says. I do and then tip the container into the waste bin. I screw the top on the jar and set it on the bench for a nurse to collect. There is more product than I thought and it is not identifiable. Dark*

[40] The jargon of work is also evident in how procedures are articulated. Accordingly, a "termination of pregnancy" is a "termination" or "TOP". To distinguish between a surgical termination of pregnancy at Lyndhurst and a medical termination of pregnancy the terms "STOP or in contrast a "medical" or "MTOP" are used. As Lyndhurst was a referring service Christchurch Women's Hospital, a surgical procedure there under general anaesthetic was called a "GA" and a second trimester induction of labour a "PG" or "PG TOP", the PG referring to prostaglandin.

red blood and soft pieces of tissue with some greyish tissue as well. The nurse aid tells me that there are a couple of the nurses who really hate this task and gag – I don't know if she means literally. She says that the washing of used instruments and dealing with products is a bit yuck. Sometimes she gets some "floaters" and identifiable "bits" in there. "Swimmers" one of the nurses calls them. I get the impression she doesn't think about it too much as she is doing it and I notice that I disengage from the tasks as I do them. She mentions the "whole one", the intact embryo that staff encountered several weeks before, and says that she hadn't seen one before either.

The terminology that is employed by staff at Lyndhurst relates to the tasks that they undertake, and one of these sets of tasks being the removal of pregnancy. This removal concerns not merely the embryo, as the nurse in the previous quote discusses, the products of conception is "everything that's inside the uterus, so there's the lining of the uterus, there's the embryo, there's the placenta, the cord, the tissue, blood" (Interview 16). A successful surgical procedure and the ongoing health of the woman relies on the abortion being 'complete' and that there is nothing left behind. For example, for a surgical abortion, the operating doctor may check what has been suctioned from the uterus by assessing the volume of product that has been extracted in the operating theatre, by checking the nature of the products through a sieve in the sluice room,[41] or as part of the procedure by suctioning and curetting when the feel of the inside of the uterus via the instruments changes from smooth to rough. These all inform the doctor about the completeness of the abortion and of the shift of the abortion-related pregnancy from inside to outside of the woman's body. The removal of the abortion-related pregnancy from uterus makes it visible, yet, no more certain concerning how it is described.

Wholes and Parts

When the abortion-related pregnancy is mobilised out of the operating theatre and into the sluice room, additional terms are added to describe it - "floaters", "swimmers", "bits" and a "whole one". In the sluice room, wording takes form in more informal, behind-the-scenes circumstances, as this relates to the work done in this particular setting. This site is separate from the moderating circumstances of operating theatre and other spaces where the patient is actively present. Moreover, in addition to where the abortion-related pregnancy is located, terms are shaped by different modes of expertise as it shifts from sites like the operating

[41] This is only on occasion, particularly with early gestations.

theatre where doctors and nurses assemble to the sluice room. In contrast to the doctors detailed sieving and sorting of pregnancy tissue noted above, the nurse aid works with tissue with more emphasis on the practicalities of work. They both engage with the pregnancy tissue but have different work to do. As noted in the fieldnotes above, one of the tasks of the nurse aid is to clean the instruments and brush from these instruments, the fragments of the abortion-related pregnancy, and the blood and tissue that find their way onto the instruments because of the procedure. Further, sorting of tissue from apparatus is described below:

> I20: ... if there's anything that's taken out and put in the dish, I try to put it back into the container rather than other people having to clear it away and come across that…And others will put product [container] in the bin and that will be about it and then you'll lift the cloth [covering the dish] and hmmmm, there's an arm in there…[laughter]…Oh God, and then you have to fish the thing back out again, well I do, I think it all has to go together really, it shouldn't be separated…I don't know what is pregnancy tissue, really, or what's just tissue, so I just keep it all together.
>
> (Interview 20)

This assembling of the abortion-related pregnancy as bits or whole ones, as sieved and sorted or kept altogether, affords a version of the abortion-related pregnancy as wholes and parts. In the process of an abortion procedure, an abortion-related pregnancy does not travel from the inside of the uterus to the outside of the uterus in the same form and all together at once or strictly from one destination to another.

From the quote above we come to know how some of the abortion-related pregnancy may be transitioned into a container, while other parts of the abortion-related pregnancy might be put in a dish then reassembled again, albeit in a different form than in the uterus, by the nurse aid who keeps it all together. She does so with the entity in front of her that is not one thing – there is material that she identifies and reassembles with that which is indistinguishable but connected, that in its separation "has to go together". Conversely, at other times, on rare occasions, the separation of the abortion-related pregnancy from the uterus of the woman makes a different type of 'whole'.

> *Today at work, a nurse aid asks me if I want to see "a whole one". This is a rare event. I accompany the nurse aid to the sluice room. We assemble side by side at the stainless steel bench and the nurse aid reaches up to grasp a small clear plastic hospital jar with a screw top lid off the shallow depth shelf. The top is*

unscrewed and its contents are tipped into a small stainless steel bowl that sits on the bench. I look into the bowl and see an embryo and a small amount of clear fluid. The embryo is lying on its right side – as a whole one it has a side – and its shape at the back follows a shallow curve and it is about the size of the area from the tip of my index finger down to the first joint. It is pink, smooth looking, translucent and shiny. The 'tail' of the embryo has retracted by this stage and is no longer present. There are small rounded developing limbs. At the ends of the lower limbs, there are five dots that indicate developing toes. At the ends of the upper limbs, the developing hands and fingers seem less defined – almost blunted, paddle-like. The translucent rounded head is disproportionately large. Its defining features are few and subtle. There is a black dot, slightly out of proportion on the larger side, about the size of the circle in this typed letter 'a' which is the eye developing. To comment on proportion at all means I am making comparisons with other eyes on other heads – its 'whole' form affords this to me as a novice in this situation with this 'material'. Further to the right and here is a little ear. I cannot stay, I need to get to my next counselling appointment. I thank the nurse aid who says to me "I think everyone who works here should know".

In the excerpt above, in the sluice room, a 'whole one' is revealed. Even the products of conception may have its wholes and parts. In the fieldnotes above, I am using the word 'embryo'. I have made this decision about language not because of my encounters with other embryos, but from a set of black and white sketches of foetal development that are present as part of my social work toolkit in my office. In counselling appointments, I regularly show these sketches to service users should they wish to see some of the stages of foetal development. Here, I find the intimacy afforded by the sketches extended by the presence of the embryo in a bowl on the sluice room bench.

In contrast to the previous abortion-related pregnancies that must be gathered together, in part because there is uncertainty about the difference between the types of tissue that the 'products of conception' is comprised of, the embryo in front of me has emerging but identifiable features. I name these in the fieldnotes: limbs, toes, hands, fingers – developing but visibly distinct.

Much like my reference to the sketches, in the notes above I have made comparisons with what I see in front of me and the 'developed' anatomical parts of the collective of human actors of which I am part of. Latour (1999) talks of the multiple inscriptions, or 'references', of

maps and aerial photographs, that make reference to the forest in his study of the Amazon forest in Boa Vista. Above, I have gathered together my own set of references, sketches, comparisons of human form with the abortion-related pregnancy in front of me, to articulate an embryo.

Similar to Latour (2010) and his factishes, in the space of the sluice room the separate and clean embryo that sits in a small stainless steel bowl represents a truth in the wake of its fabricated arrangements. The embryo is on display for educational purposes, to inform, to impart knowledge. Alongside this, it also holds the qualities of interpretation. The nurse aid says to me "the whole ones aren't quite as bad as the one's in bits…it doesn't seem real maybe". This reality, the embryo in front of us, the constructed arrangement with actual material from the uterus, is a reality that doesn't seem real. A truth that is distant from itself.

The nurse aid speaks of uncertainties. The 'whole one' doesn't quite seem *real*. A 'real' what? We might also be moved to ask, what is the 'whole one' a 'whole' of? Drawing on Latour (2010) and his concept of factishes, these versions of pregnancy are both real and have both been made through the sets of practices within Lyndhurst, yet they are open to the interpretive gaze and nuanced beliefs of those who assemble with them.

Articulation Devices

> *…'voices' do not exist in and of themselves. They do not reflect something that is pre-given. Rather they are constituted or 'articulated' into being in material arrangements which include social, technological and corporeal relations*
>
> *(Moser and Law, 2003, p. 494).*

Like Moser and Law (2003), I argue that a 'voice' is relationally assembled, 'articulated' into being through that which is social, technological and corporeal. The emergence of a 'voice' is that which is mediated through the work between human and non-human actors. Aligned with the concept of 'articulation', a 'voice' need not be limited to that which is verbal. In the account by Moser and Law (2003), a 'voice' for people with specific disabilities is produced through a human/non-human arrangements between a disabled person, their wheelchair, and computerised devices that, when they combine, mediates this 'voice'. Or more broadly, the power to act is demonstrated in the movement of the wheelchair ensemble through physical

spaces, the automated expression of the disabled person's desires, and the capacity to exert some control over the living environment.

Following Moser and Law's (2003) notion of 'articulating a voice', in this section, I overlay additional elements of Latour's (2010) concept 'factish' to reveal further variants of the abortion-related pregnancy – those are produced through the engagement with foetal models and protestor pamphlets. Extending on this, I attempt to show that the diverse articulations of the abortion-related pregnancy that have been presented thus far are neither groundless in their construction, nor are they without their makers and exist in their own right as fact. They are 'factish', a fabrication comprising of entangled facts and of fetish (Latour, 2010). A fetish, offered in the initial section on foetal models, is taken to mean that which is made and yet revered as real.

The reality that any given abortion-related pregnancy may not be wholly true is not really the concern. What is of interest is an exploration of the factish qualities of the abortion-related pregnancy, how the 'facts' about the abortion-related pregnancy are assembled, and who and what they assemble with. It is the relations between actors that is key. In this way, the models and the pamphlets of concern described in this section are nothing on their own.

While the voice and words are called upon to articulate the abortion-related pregnancy, as is the character of articulation, we can notice something else: it is the leaky boundaries between wording and materialities that extend upon the agency of wording to offer the prospect of making the 'baby', that is materiality present in the models and pamphlet, 'human'.

Drawing from Haraway (1991) and her notion of the 'cyborg', the abortion-related pregnancy can be considered in this way - as a cyborg, a hybrid, a "creature of social reality as well as a creature of fiction", where the boundary between social and the material has collapsed (Haraway, 1991, p. 149). For the abortion-related pregnancy, the use of foetal models by humans and the 'human pamphlet' described in this section, afford a platform from which certain foetal cyborgs populate the assemblage of abortion. We enter first, into a community service that seeks to counsel women who are considering their pregnancy outcome.

Objects that 'Speak'!

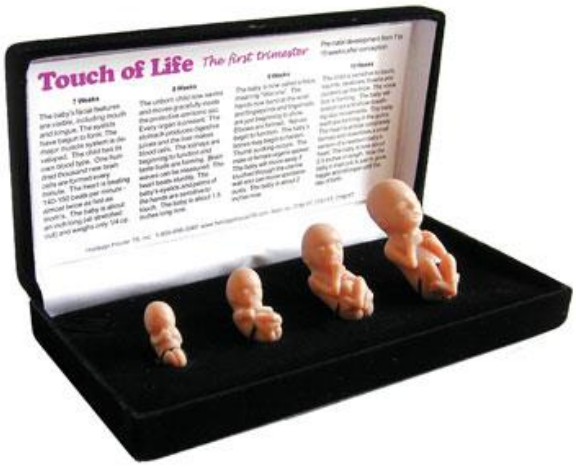

Figure 1. Maternal Source: Quality products and gifts for pregnancy, childbirth and parenting

(n.d.). http://www.maternalsource.com/Maternal%20Source%20Website/prod40.htm

Letitia: Where... [Pause]…is this, is this from America? [Box set of replica foetuses called 'Touch of Life: The first trimester' to show foetal development from 7 to 10 weeks gestation – soft, pink, rubbery type material]

Ia: Yes. We've only just got that last year and we find that it's the strongest tool we have because the girls will say, "well, how big is the foetus at the moment", and we say "well, this is the size and look where the baby's developmental stage is now".

Ib: And they don't have to touch it, you know, it's not forced on them.

Ia: We sort of just give them the box and they just look at it themselves, we don't say a word.

[Pause]

I've found with some of the mothers of girls that come in as a backup support person, and they sit behind while we're talking, they want to see this, and the mothers look at this and say, "oh my goodness, this is what I wasn't given when I had my baby"…

…I like them because they're soft and they're more realistic. They're not bloody, they're not nasty…

Ib: Some of the old ones they had, they were all hard…

Ia: ...a bit unrealistic

[Pause]

Ia: We find they are probably the most important thing to give the girls, the fullness of the truth really, that's what they want when they come here. We give them all the facts.

(Interview 11 and 12)

The abortion-related pregnancy in this community counselling service takes form as a collection of models in a box that are gathered together to show foetuses in different stages of development. They are comprised not of the substances of the womb but of synthetic material - rubber. There is text that fills the inside lid of the black velvety hinged box. When the lid is open, the text sits above each of the rubber foetuses, and in these four columns the text gives an account of the stage of development that each foetus is at. A heading sits above the four columns that reads, *Touch of Life: The First Trimester.* This reference to 'touch' opens up the prospect of the tactile availability of this abortion-related pregnancy, and further, a sense of equivalence to and connection to 'life' and a first trimester pregnancy.

The models provide a set of foetuses that are separate from the woman and the *in utero* environment, including the tissue and fluid they would be connected to had they been 'real'. These foetuses are 'clean' - they are "not bloody" and "not nasty", they can be looked at and are "soft" to touch (Interview 11). Yet at the same time, they are complete, a teaching device for the "girls" that enter this setting. Yet, the word 'girls' denotes an incompleteness, a female being in a state of becoming, not yet fully autonomous and self-determining, that is present alongside the box of foetal models that offer "the fullness of the truth", "all the facts" (Interview 11).

As Latour (2010) argues, facts are fabricated one way or another, they do not come into being on their own. Yet they may be afforded autonomous and 'scientific' status. The foetal models reference the universality of an abortion-related pregnancy and do so through the universality ascribed to the anatomical body where the structure of the body sets a standard. Because of this, the foetal models can be used with different women in different appointments across different hours, days, and years, and still retain their universality.

Of course any given foetal model in the box is not the foetus of the woman who enters into a counselling arrangement. Yet, due to their recognisable foetal shape and flesh-like colouring,

the models are anthropomorphised representations of a pregnancy that could be just like theirs. Because the woman's foetus is hidden inside her body and cannot be referenced directly, there is a compromise, and the foetal models are called upon as a delegate for this entity. While on one hand, any particular model is not any particular women's foetus, at the same time, the woman attending the counselling session can see that the version of the foetus in front of her that can be viewed, touched and held, could be just like the foetus obscured within her body. Within a network of relations, service users become alerted to the presence of non-human actors that they may come to co-exist with and consider as part of themselves (Callon and Rabeharisoa, 2003).

However, despite the widely used representations of a pregnancy described above, there is no universal abortion-related pregnancy. This is a similar argument to Mol (2002) when she claims that there is no such thing as 'the' body. Mol (2002) argues in her work on atherosclerosis that what the body *'is'* is not singular, but rather an outcome of how the body is enacted at different sites through various sets of practices. For example, with atherosclerosis, leg arteries may be of focus (Mol, 2002). A patient may have access to the functioning of the leg arteries through their embodied experience of pain. In contrast, a technician has access to the leg arteries through technical equipment and can produce a measurement of their function with this apparatus. If the technicians' readings are normal but the patient feels pain, then ultimately they are attending to different 'signs'. Consequently, while they are both attending to leg arteries, they are no longer attending to a common 'object' or body, but a 'body multiple' (Mol, 2002). In this way, in order to 'know' the body, attending to specific and local practices is key.

Related to Mol (2002) and her concept of multiplicity, we are not dealing with a singular or common abortion-related pregnancy, but following how specific abortion-related pregnancies emerge in the way they do and through what means. From these considerations, we can think about *where* the abortion-related pregnancy is. What are the sites of relevance? This involves a shift from thinking initially about the universality of an abortion-related pregnancy to the local context as it is embedded in the global. Indeed, the local and global cannot be divorced from the other. Just like the attention to the entangled relationships between human and non-human actors, the local and global are intertwined. Accordingly, the foetal models that are used at the community counselling service were not produced at this local service in their material form. They came to be from somewhere else. Here the consideration of site opens up to global effects. To illustrate this, an example from a US website that sell these models, available in "pink ['white'], brown or black", follows:

> This new foetal model set is not like any you've seen or used before. The babies were individually sculpted to have a personality of their own. The detail is amazing, and the life-like feel of the skin brings home the humanity of the unborn baby. They can easily be removed from the black velvet display box for people to hold. The babies are 7, 8, 9, and 10 weeks after conception. The accuracy of the developmental stages was assured by using medical descriptions and actual scaled photos.
>
> *Maternal Source: Quality products and gifts for pregnancy, childbirth and parenting (n.d.)*
> *http://www.maternalsource.com/Maternal%20Source%20Website/prod40.htm*

As the quote above explains, by reference to the use of medical descriptions and 'actual' scaled models, these foetal models carry the residue of their origins in scientific fact, yet, they are a translation of this. These models have been overlaid with a 'personality of their own' and the 'life-like feel of skin'. This overlay foregrounds the 'humanity' of these objects, rather than presenting a medical reference to the developing foetus. Further to this, the specific origins of the models and the arrangements in which they are active impacts upon the reality that they are part of mediating.

The models were imported from the United States of America and link in with a wider global movement, sometimes referred to as 'pro-life' - although the term 'pro-life' is not particularly useful concerning the heterogeneity of what this may mean in any given 'pro-life' context and setting. However, through this 'pro-life' connection the foetal models have come to make their way across the world to be used as tools in related settings with individuals from a different country and cultural profile. Then they sit, a box with rubber models, that are inert until the lid is lifted and they are passed from the community counsellor to the pregnant woman. It is then that they become active.

This abortion-related pregnancy is cultivated locally in the moment. Moreover, the foetal models in the community counselling service produce a 'baby' in the sets of relations that occur at a local site with a box of models, a pregnant woman, and a counsellor. The community counsellors need not say anything – they "don't say a word" - the artefact speaks! Similar to the argument of Moser and Law (2003) with their analysis of 'Rolltalk', a computer system that extends the capacities of multiply disabled people, such as generating speech, the box of foetal models affords an "extension" to the counsellor – it speaks for the counsellors and articulates the next phase of interaction (p. 5). But building on this, when artefacts are called

upon to speak, there is a shift that occurs from its origins, its manufacture, and the use of the object, to its representation (Latour, 2010). In this way, the community counsellor appears to acquiesce agency and their own opinion to the power of the artefact that for a time takes centre stage.

The foetal models may be considered as a 'fetish', a fabricated object that incites talk, a "talk-maker" (Latour, 2010, p. 4). A 'fetish', in this context is derived from anthropological terminology and refers to an artefact, an inanimate object that has acquired certain qualities of embodied potency, an object of devotion or fixation. A fetish is not an object in isolation, nor is it a 'mere' object. A fetish is an object that exists with the context of 'strings of action' and in this way it is mediated to act and also mediates other actants to 'do' something; thus, it is transformative (Latour, 2005; 2010).

Accordingly, following the ideas of Latour (2010), the foetal models are articulated as "truth" and "the facts" according to the community counsellors who engage these actors (Interview 11 and 12). However, as Law and Mol (2008) note, action is very different from control and no one actor controls because they do not act alone. Thus, the foetal models have no power on their own. They only have agency when other actors are enrolled and invested in the practices of producing a baby.

> I4: …I think people just ignore that this is a baby, that [abortion] is murder…And if you believe that it's a baby from conception, then it's not a 'problem', it's a baby. It's not a problem to be fixed is it? It's a living creature…
>
> (Interview 4)

Belief, as Latour (2010) argues, has nothing to do with cognition, but is rather a relational achievement. And the achievement of belief may fail. We may recognise the foetal models as being constructed in that they capture a number of properties of the invisible pregnancy. It is precisely because early pregnancy within the body is invisible that it necessitates fabrication in order to become accessible. In this way there is a recognition that they, the foetal models, are not 'real'. However, this does not mean that they don't have power and transformative effects. Yet, if the achievement of belief is to occur, the model will be looked upon and touched as an autonomous entity. In this way the practices with the foetal models makes the impossible possible, and disrupts the perspectives that the actor describes below:

> I42: …I know that there's a huge foetal advocacy politics where doctors advocate for the foetus etc. But there isn't really a foetus except that foetus that's part of the

> mother. Because as soon as it's not in the mother anymore it's no longer a foetus anymore, it's a baby. And they can be baby advocates. Maybe in certain circumstances it's appropriate but we can't forget that the foetus is dependant, it's not a separate being.
>
> (Interview 42)

Instead of a foetus, as this is dependant and part of the mother, the foetal models mediate a foetus that I would argue is implicated in a double bind – both independent and separate from the 'mother' but also dependant in that what is evoked is a baby that is dependent upon the 'mother' when the foetal models 'stand in' for her baby. The foetal models muddy the boundaries of foetal politics concerning where the baby is in space, and further, it places independence and dependence on a shifting continuum rather than being of dual composition.[42] The "baby advocates" do not wait until the foetus is no longer inside the body of the 'mother' and is born (Interview 41). Instead, they engage tools such as the foetal models to advocate for the 'baby' mere weeks into its intrauterine trajectory. The object, the rubber foetal models, in the interactions of the counselling session, become 'a baby' – a symbolic object that is autonomous in its own right. The models are not seen to be made and moulded from rubber, to have travelled from the US to this Christchurch community setting, and to have played a role in articulating a foetus. Instead, the foetal model *is* the foetus.

The Human-Pamphlet

> *"We must, with our words, also give the baby a face and make her a part of our human family" (Gans Turner and Spaulding Balch, n.d., p. 9).*

The opening quote of Gans Turner and Spaulding Balch (n.d.) derives from a 'package' of text for 'pro-life' actors on the language to use when engaged in debate about abortion. Implicit in this quote is the concept of fabrication, an element of the 'factish' (Latour, 2010). Fabrication refers both to processes of construction as well as the constructing of falsehoods. So, in the case of the quote above, words are employed to generate a face, a gender by the use of 'her, and a familial place for the 'baby', that has not yet been realised.

Fabrication in science implies misconduct and generally concerns intentional falsifying of research results. Yet, in terms of construction, both scientists and storytellers are active in the

[42] For example, Rothman (1989) presents a feminist position where the foetus is dependent on and part of the mother's body and in way is not a separate entity or person in its own right.

production of their work (Latour, 2010).[43] My use of the term fabrication is not meant to imply dishonest and deviant behaviour, but to place focus on the creative and collective activities through which the abortion-related pregnancy is composed and represented. As part of this, how these representations are perceived, as falsehood or fact, is contingent on a myriad of factors, but mostly this concerns what we believe, or rather, what is believed to be true and inversely, what is believed to be a sham. To unpack this further, an image of a pamphlet is included below.

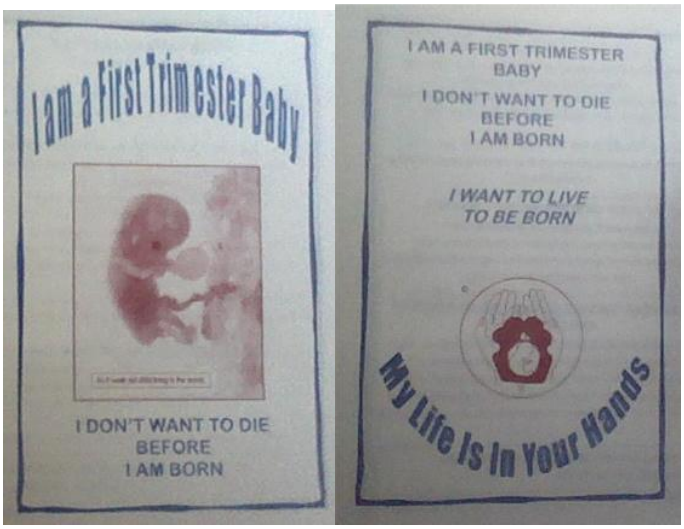

Figure 2. Protester/Sidewalk Counsellor Pamphlet accessed from the gate at Lyndhurst (I am a first trimester baby, n.d.)

Pamphlets, like the pamphlet in the image above, assembled a further variant of the abortion-related pregnancy. During my fieldwork I saw protesters (as Lyndhurst staff defined them), or sidewalk counsellors (as these actors defined themselves),[44] holding these pamphlets as they stood on the footpath outside the gate of Lyndhurst.[45] These actors, the protestors and their

[43] Indeed, Latour and Woolgar (1986) meticulously document the production of scientific facts in their book, Laboratory Life.
[44] Chapter 4 addresses how sites and texts comprise the identities of these and other groups.
[45] There are other versions of the human-pamphlet that I have gathered and viewed over the course of this research -the more graphic and confronting foetal representations that make their way into 'pro-life' paraphernalia. Rather than the wholes and parts that emerge from the practice of abortion in a clinic setting, 'fetal monsters', as Larsen (1999) discusses, have an intention outside of treatment, and are constructed to shock and deter. Rosalind Petchesky (1987) from her work on the culture and politics of fetal imagery writes: "…a picture of a dead fetus is worth a thousand words. Chaste silhouettes of the

pamphlets, were not a welcoming committee that assembled at the entrance to Lyndhurst and afforded a smooth passage into the service for approaching service users. Rather, the actors on the footpath clashed against the practices within the hospital walls. Their role was one of disruption, and they adhered to a different abortion reality of which the pamphlets are key. I was privy to some of these practices of disruption.

On occasion I would see pamphlets held at the end of the protestors outstretched arms as they sought to make a connection with service users who approached and walked through the gate. I tried, at times, to access the pamphlets by approaching the protestors at the gate, asking if I could have one. However, my requests were declined. As a staff member at Lyndhurst, I was approaching these actors from the wrong side of the gate and was not their intended audience[46]. Ultimately, this did not matter and the pamphlets were made available to me in another way.

I picked up the pamphlet, shown via the image above, one afternoon when I left Lyndhurst after work. I have retrieved all of my protestor pamphlets this way – from the ground on the footpath outside of Lyndhurst, woven through the wire netting of the gate, or stuck into a gap in the join between one of the wooden gate posts and the painted corrugated iron fence that surrounds the site. Yet, pamphlets do not absentmindedly fall this way. It takes effort to thread pamphlets through the wire of the gate or work them into a crack in the fence. The ways that the pamphlets are left, or even that they are left behind at all by the people who usually hold and seek to distribute them, suggests an intention.

The pamphlets had been left because they might just be picked up. Not by me or passers-by but by the women who might engage the services of Lyndhurst. In this way, the pamphlets are not merely tools to be used by the human protesters when they stand at the gate. The

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fetal form, or necrophilic photographs of its remains, litter the background of any abortion talk…The strategy of antiabortionists to make fetal personhood a self-fulfilling prophecy by making the fetus a public presence addresses a visually orientated culture. Meanwhile, finding "positive" images and symbols of abortion hard to imagine, feminists and other prochoice advocates have all too readily ceded the visual terrain" (p. 264). As one of the doctors at Lyndhurst noted on her return from an international conference:

> *Yeah, there were signs showing bits and pieces….Like the guys out the front yesterday holding up that picture of a foetus. What about holding up that picture of a mother of three left to die after an illegal abortion in a Connecticut hotel room. They don't hold that up.*

The comparison here is made with the highly circulated image of Gerri Santoro, a symbolic 'pro-choice' image that 'speaks' to the causalities of illegal abortion.

[46] Again, see Chapter 4 concerning how the gate plays a part in ordering groups and work.

pamphlets were expected to do something on their own terms, to make a difference, to act.[47] The human actors, the protestors, were not necessary for this action. In the absence of the protestors they had once assembled with, these pamphlets 'speak' and articulate the abortion-related pregnancy and the accompanying intention of the pamphlet on their own. This responsibility indicates that it is also the pamphlets that pick something up – the role of the protestor. They do so in the form of the words and imagery that register and describe an abortion-related pregnancy. Some of these elements of the pamphlet are disentangled below.

The pamphlet can be read as an articulation package. On the cover of the pamphlet there is a heading in arched dark blue font that reads: "I am a First Trimester Baby". The abortion-related pregnancy in the pamphlet proclaims a state of being with the words "I am…" (the singular present simple tense of the verb *to be)*. The wording "I am a First Trimester Baby" presents an 'inversion' of the practices at Lyndhurst. Following the notion of factish, opposing groups may seek to invert the claims of others as 'fetishes' or falsehoods and assert their constructions as 'fact' (Latour, 2010). The presence of the pamphlet and its proclamation as a first trimester *baby* outside Lyndhurst's gate juxtaposes the activities of the first trimester termination of pregnancy service inside the gate and within the clinic walls. What these different sites and arrangements share is the same gestational parameters of a first trimester abortion-related pregnancy. However, their presentation varies.

A photographic picture of a developing embryo is in the centre of the frame. The curve of the embryos back is to the left and on the right it is attached by its umbilical cord to the placenta and uterine wall, which extends down the length of the right hand frame. The image and surrounding space is also depicted in shades of pink. This detail exceeds that which routine ultrasound scanning practices reveal with its black and white fuzzy tones, or even the more technologically advanced but muted monochromatic tones of 3D imaging.[48] Moreover, the colouring is different. Shades of pink and blue have made their way onto the pamphlet, whereas shades of black, white and brown occupy the ultrasound images. I cannot be certain if for the pamphlet the pink and blue colours are intentionally symbolic of the pinkish tone of conventional Western skin, or the traditional representations of gender – pink for girls and

[47] See, for example, Prior (2008) who argues that when documents are considered as 'active agents' they are *part of* not outside of social interactions. Further, that a focus on the 'function' of documents, like the attention to the pamphlet in this chapter, means that documents can be considered as "active agents" rather than "containers of content" and in this way we may be made more aware of how documents come into being and how they function in and of social interactions and arrangements including their exchanges with other actors and their circulation within networks (Prior, 2008, p. 824).
[48] See chapter Circulating references for a discussion of ultrasound scanning and its reference to pregnancy

blue for boys. By contrast, ultrasound images are without this enrichment. It is merely tone that is present in this depiction. And there is more to add.

Below the image of the embryo on the pamphlet, there are words in a dark pink framed textbox that reads, "An 8 week old child living in the womb". In contrast to the initial heading, there is no 'I' in the textbox but rather the use of 'An'. Moreover, the 'baby', as the pamphlet identifies itself, has changed to "child". The "child" that is referenced is not a specific "child". We are not privy to who this child is or who might be 'with child'. The phrase refers to unspecified 8 week pregnancies that are identified as such in relation to standardised intervals of foetal development. As such, much of the phrase lends itself to the sphere of medicine and to scientific fact. The image has been attired as a technical figure by calling upon the scale of gestation.

This move that exhibits the 'face' of science, asserts a shift away from the 'truth' that is compiled and fabricated, towards the 'truth' that is fact (Latour, 2010). However, this move is not fully realised. The word "child" is a marker of this. This 'child' cannot retain the claim of science for the very matter than 8 week old foetuses cannot speak. Evidence of this reality cannot be backed by even the most innovative scientific technologies. The child on the cover of the pamphlet is not a child in the world, but a child of a world within the body of a pregnant woman, and in this case, made visible and audible on the page. The speaking child is the mode with which to provoke a transformation and engage, animate, and provoke. And, with the word child, we are made sensitive to what a continuing pregnancy might be. In this way, the pamphlet cultivates potential.

The threat to this potential can be found in the final lines of text displayed under the foetal image. In dark blue wording we switch back to the initial voice, the first trimester baby with the phrase, "I don't want to die before I am born". In the pamphlet this baby speaks before it is born and in text we are made aware of its desires, its vulnerability, and the threat of death.[49] Here the intentions of the pamphlet are made clear.

Claims about abortion involve action that organises the body in certain ways. Protestors work to cultivate intimacy with elusive pregnancies that, because they reside within the body, are

[49] The inversion of this can be seen in images used by 'pro-choice' groups such as the symbolic image of the coat-hanger and the photo of Geraldine Santoro, a woman who haemorrhaged to death alone in the motel room from a botched abortion. These images contrast in that the 'anti-abortion' groups may depict an abortion outcome for the personified pregnancy, while the pro-choice movement images may indicate the consequences of illegal abortion for women.

invisible, and in this way, inaccessible. When a pregnancy that is of and within the woman's body is presented as an entity that is separate and outside of the body, it becomes fetishized. The body may be objectified as the place where the pregnancy resides and the pregnancy is redefined as having a distinct identity, not only in its isolation from the body, but in the other elements that it is assembled with. In this way, the pamphlet mediates access to a visible and tangible abortion-related pregnancy where words and imagery allow a 'baby' to be revealed. An image, a colour photograph, and an array of words give the pregnancy a 'voice', and in this way, 'add life' to the paper that holds these articulations together. These articulation cues afford a different move from the foetal models that can be touched and held. The overlay of words and imagery presented on paper work to build a further human interpretation where we are able to see to an invisible pregnancy and know its mind and its will.

The power of the pamphlet, and to a certain degree the models too, relies on the capacity for its humanity to be revealed and for this to be considered as real or as fact. In this way, the pamphlet becomes other than itself, a subject rather than an object. It speaks in place of the pro-life group concerning their cause by generating the representation of a baby. Alongside the factual assertion sits additional claims that the image has certain qualities. In the case of the 'photographic' image above left, these qualities include a 'voice'. The target audience, the pregnant woman, is also the subject of the pamphlet. Inside the pamphlet she is referred to as "mother" and in this way she is thrust to a distant future, configured as a parent rather than being pregnant. The pamphlet, then, seeks to close the gap between a present and a possible reality.

The back cover of the pamphlet includes a further pink image, not a photographic image, but a symbolic image of a small "first trimester baby" encapsulated in a circular border that sits upon larger cupped hands. The subsequent and final dark blue text concludes with the statement "My Life Is In Your Hands" (I am, n.d.). Life and death are reaffirmed as part of the narrative of the pamphlet.

This articulation is more clearly a fetish that is fabricated. While the fetish is fabricated, it is still imbued with qualities similar to the fetish that is real. Voice, desire, vulnerability are present through the portrayal of expression, and the text indicates a desire to be born, fear about what may transpire, and a plea for mercy: "My life is in your hands". Inevitably the fabricator of the fetish plays a part in the manipulation of the fetish, its public portrayal, and in the making of its history. As Latour (2010) states, "If you admit that you fabricate your own

fetishes yourselves, then you must then acknowledge that you pull their strings as a puppeteer would" (p. 7).

Thus, while the stylised image is on one hand, clearly fabricated, it still has the power to act (like the 'real' artefact), and mediate other actors to *do* something – join the cause, not have an abortion, or formulate ideas about what abortion is. Fetishes (fabricated or 'real') by nature are 'rationally' known to be constructed. Depending on belief, the fetish can be used to influence others, or conversely, it may be discredited as 'mere' fabrication.

Similar to the box of foetal models, the pamphlet seeks to make the abortion-related pregnancy visible, giving it a voice and using specific terms to refer to the abortion-related pregnancy and the potential service user. As Duden (1999) states, "The fetuses we live with today were first conceived not in the womb, but in visualising technologies" (p.16). While 'low tech', the pamphlet functions as one of these visualising devices. In contrast with the terminologies within Lyndhurst that articulate the abortion-related pregnancy as a substance, the versions in the pamphlet generates a subject. In this way, the pamphlet itself, with its images and the words, becomes other than itself. It too takes on the properties of the subject rather than object, with the desires (in text) and agential qualities that this involves.

As Latour (2010) argues, object and subject are not distinct. A distinct object or subject is an inadequate means to describe the shape changing qualities of an actor such as the pamphlet. And it does change shape, from paper to baby, as it assembles a particular version of the abortion-related pregnancy. The pamphlet in effect dismantles the notion of fact and belief, object and subject, non-human and human - there are traces of both in the words and images. They entangle and are impossible to set apart. The links between human and non-human actors are so pervasive, that all entities can be considered to be hybrids.[50]

As a hybrid, the belief (interpretation of the human pamphlet) and the tool (the pamphlet itself) are inherently fused. As Haraway (1991) states, "The boundary is always permeable between tool and myth, instrument and concept, historical systems of social relations and historical anatomies of possible bodies, including objects of knowledge. Indeed, myth and tool mutually constitute each other" (p. 164). Whilst Haraway (1991) argues that technologies are tools for recrafting the body, and she is referring to the body of women, at the gate of Lyndhurst we can see the abortion-related pregnancy that has been recrafted as a baby.

[50] This is what Latour (1993) has termed quasi-objects and quasi-subjects.

If the pamphlet elicits a response from the viewer, whether this be the service user, myself as a staff member and beginner researcher, activists, advocates, or you the reader, then it surely has served its purpose. It has done something to make a difference. It has continued a chain of actions put in place by the actors before it. It acts. The power of the articulation tool, the human pamphlet, relies on the capacity for this arrangement to imbue autonomy, to become other than itself, through belief to become some sort of reality, as if there were 'a' reality, on its own, separate from its fabrication (see Latour, 2010). Likewise, in *Laboratory Life*, Latour and Woolgar (1986) argue that 'reality' "cannot be used to explain why a statement becomes a fact, as it is only once it becomes a fact that the effect of reality is obtained" (p. 180).

To be taken in by the pamphlet, to borrow from Latour (2010), requires a belief that this fetish is real and accordingly, the image, the likeness and the ascribed qualities assimilate into themselves. In this case, the belief facilitates the representation of an unfabricated fetish, it has an illusory quality. An unfabricated fetish performs as separate from its maker, and presents as real what has been made when it exudes autonomy and there exists an implicit shift in focus from the maker of the artefact to the outcome. In its autonomy and as real, a fetish presents as fact – it is believed in and believed to be true and is powerful in this way. Moreover, if the fetish maker is taken in by their own fabrication, then the maker joins those who believe in the reality of the fetish as a deceived believer rather than the fetish maker.

Conclusion

This chapter has described some of the ways in which abortion controversies are assembled – how they are given form in and through the practices of human and non-human actors. Across a number of sites the multiplicity of the abortion-related pregnancy has been revealed. Various articulations of the abortion-related pregnancy have been described. By drawing from Latour's (2010) notion of the factish, the 'truth' about what the abortion-related pregnancy is proves to be a dynamic one. Indeed, there is no such thing as *the* abortion-related pregnancy.

The clumsy and made-up wording, 'the abortion-related pregnancy', was coined to articulate its name-changing, shaping changing qualities and to traverse the different words that are ascribed to it and disputed by other actors. But further to this, this term seeks to account for the articulation of this pregnancy that is to do with abortion. As I have tried to show, articulation includes the 'voice', the words that are chosen and uttered, but more than this, it is enriched by the inclusion of other elements and other modes of 'speaking'. I have not

provided an exhaustive list of words deployed to articulate the abortion-related pregnancy nor the full scope of pregnancy configurations that take form. There are, of course, many other versions. Rather, I have offered a sample.

Engaging with the pregnancy occurs across a number of sites, where different wording is cultivated as this relates to the practice concerned. Within Lyndhurst, versions of pregnancy are located predominantly in the operating theatre and in the sluice room, and less frequently on the recovery ward. Eventually this pregnancy, now clinically worded as the "products of conception" or "pregnancy tissue", is mobilised from the clinic in one of two directions. Either, and most often, it is collected and taken for medical disposal, or less often, it is mobilised out of the clinic by women who take this tissue into private spaces and locations or discretely to public land.

Different devices are key to the technique of articulation. Moreover, the impetus for 'making' the abortion-related pregnancy varies. Different versions emerge in disparate but connected practices. At Lyndhurst, the abortion-related pregnancy is part of treatment where work is undertaken to make it separate from the woman, apart, and consequently, in parts. In the community counselling setting with the foetal models and at the gate of Lyndhurst where protestors/sidewalk counsellors assemble with or leave pamphlets, an abortion-related pregnancy is configured to disrupt the work of abortion provision, to keep the abortion-related pregnancy within the body, whole.

When the pamphlet is seen on its own at the gate at Lyndhurst it is afforded distance between those who made the pamphlet and the pamphlet itself. In the case of the 'human pamphlet', those who fabricate and provide this articulation of the abortion-related pregnancy barely feature at all. The pamphlet itself does the 'talking'. Yet, like the foetal models, a great deal of work has occurred in order to fabricate these documents. Take the photographic image of the foetus, for example. Is it not real? It is an 'actual' image of a real foetus. But, it is also fabricated. It is not possible to see images like this without the technology and the editing, the colouring, and the printing that makes the image into what it is that we see on the page.

What is stripped away when the pamphlet is on its own are these activities through which the pamphlet has come to be – the collective work, the discussions, the decisions, the sourcing of images, the crafting of text, the bulk manufacture of the document itself. Of interest, also, is that there is no indication upon the pages of the pamphlet as to who has produced the pamphlet, when and where. In this way, the fabricators of the pamphlet, its temporal origins and site of production, are elusive. Perhaps the absence of validating qualities in the pamphlet

that we would see in a 'peer reviewed' or scientific text weakens its power, or conversely, this absence may strengthen the presence of the first trimester baby the pamphlet is seeking to depict.

In the pamphlets at the gate, moreover, the viewer is unlikely to be privy to its interrelated texts like the advertisements for sidewalk counsellors that circulate in a pro-life magazine. These advertisements seek to enrol those that stand at the gate of Lyndhurst and weave the pamphlets into its wiring. Thus, in the absence of these further clues to the human and non-human relations that the pamphlet is inevitably nested in, and, if the pamphlet is made well, it may well appear to be an autonomous and original entity.

In the moment when I pick up the pamphlet from the ground or the wiring of the gate I do not see the assembly behind the protestor, nor them and the qualities they imbue – all that has gone into producing the pamphlet I see before me. What I see is the pamphlet, a document, and account of the abortion-related pregnancy that in its own right may be afforded the status of being a fact. Yet, the pamphlet is not a fact. It is an invitation to take a further move that is driven by the transformation it may instil in the beholder of the pamphlet. And this is a belief in a further move, that an abortion-related pregnancy does not become an abortion, but a child. Yet, at Lyndhurst there is no expectation for the abortion-related pregnancy to do exceptional things, whereas at the gate the pamphlet and this version of the abortion-related pregnancy has a monumental task. Because it is not a 'real' pregnancy, it must become one. Personhood crosses over in more ways than one – via the objects that 'speak' and the 'babies' that the objects become.

It may be tempting to discredit these 'pro-life' practices or rather to dismiss them. Yet, the abortion-related pregnancies of abortion provision and of the private spaces of services users are also fabricated. The sluice room, stainless steel bowls, textbooks, peach trees are all implicated in the production of the versions of the abortion-related pregnancy that have been described. Neither articulation of the abortion-related pregnancy, at Lyndhurst, in the community counselling setting, or at the gate, is able to reign, to convince the other actors that this is indeed the truth of the matter. As we have seen as part of wording, claims to what the abortion-related pregnancy *is* are not taken up completely by service users who link in with abortion practices. Indeed, these actors make their own claims. Language and practices may fail to translate across worlds and 'the facts' do not necessarily conquer the belief of babies or remains or bad eggs. It is because of the specificities of fabrication and articulation that the abortion-related pregnancy moves in different directions.

Chapter Four: Assembling Professional Identity

Introduction

As has been noted in previous chapters, ANT sensibilities help describe heterogeneous networks that are made up of many actors: people, biological tissue, technologies, texts, devices, artefacts, and institutions that can all be a part of an actor-network. The intention of this thesis is not to explain why, but to describe how relationships between actors are established, how they function, and to note what effects they may have. I am no different to any other researcher using this sensibility: ANT invites me to use my version of the approach to "follow the actors" (Latour, 2005) in a quest to reveal their vagaries, the vicissitudes they produce, and the associations they form.

This chapter argues against the presence of a distinct sense of self or identity that a person holds or *is.* Instead, I suggest that identity is dynamic - assembled, enacted, disrupted, and reassembled. Moreover, identity, as this takes form in professional roles and worker-client relationships, is more than an ensemble of people. What I describe in this chapter is a 'social' that is made up of patterned heterogeneous networks and is larger, and more layered, than just the people involved. The material objects and the spaces that people encounter are shown to mediate particular interactions and relationships, such as worker-client and worker-colleague relationships, that ultimately have effects on behaviours and actions.

In describing the 'social' by presenting the agency of non-humans alongside that of human actors, the active participation of non-human actors in the construction of identity is revealed. As I discuss these things, we can notice the active roles that non-human actors play in contemporary constructions of professional identity. Actors are networks of heterogeneous relations, or effects of such networks. What have sometimes been considered to be distinctly human attributes (thinking, writing, acting, empathy) are presented differently: These attributes are revealed as I describe networks that exist both within and without a body. Our 'professional identity' ideas come about through a range of effects: the way we are guided by service documentation; how we express thoughts on paper and in social media; in the way we talk, sit, stand, or walk in our workplace; and how care is practiced through the people, tools and materials and spaces we interact with.

The rationale for describing professional identity is that interactions between people are almost always mediated—by wording, by devices, by objects. As a result, objects can determine how people behave and the actions they perform. Indeed, the very reading of this thesis, most likely on a computer or tablet, are determining our actions. You read, perhaps taking notes as you do so. I chose not to leave pages blank, and you chose to open the document. What we are doing, for the moment, is part of a particular author/reader network - between me and you and the non-human actors that make this possible.

It is from this understanding that I consider professional identity in this chapter – as something that emerges in and through a relational assemblage. Identity is something that is assembled, something that 'comes into being' through specific arrangements. As Moser and Law (2003) suggest, "…everything – people, subjectivities, actions, scientific facts, technological artefacts, texts and symbols – achieve their form as a result of the network of relations in which they are located" (p. 3). In this view, as noted above, non-human actors are important mediators that both guide and constrain identity (Jerolmack and Tavory, 2014). Accordingly, 'an' identity, the memberships that actors enact, and the various boundaries that are drawn between groups, can be understood as the effects of relational work between human and non-human actors. There is no identity outside of these collective heterogeneous relations. In this chapter, actors are also constructed and defined by the premises at Lyndhurst, such as the gate at the border of the grounds, medical apparatus, and décor, and these features cannot be stripped away from the assemblage of professional identity.

In deepening my account of professional identity within this chapter, I mobilise Law's (2004) notion of 'method assemblage', explained in Chapter 1. Using this concept, reality may be understood as the gathering together, arranging and crafting of boundaries between three coexisting and interdependent components: "presence, manifest absence and absence as Otherness" (Law, 2004, p. 144).

Like Law (2004), I argue that absence and presence depend upon each other – that one invokes the other. This does not mean they exclude or oppose the other as if there were either abortion or presence (Callon and Law, 2004). As Law and Callon (2004) suggest, while "[i]n common sense it is obvious, an object or a person is either here or there and not in two places at the same time", we can also consider that there are multiple ways of ordering the world (p. 3).

Hetherington (2004) in his account of consumption and disposal practices suggests that the "erasure of objects is never complete" – that the processes of ordering can engage both

absence and presence (p. 168). For example, a holiday may be disposed of (made absent) into holiday photographs that concurrently make the holiday of the past present in a different form (Hetherington, 2004). Or a collector of artefacts may 'dispose' of his/her collection into indexing – in the index the 'real' representation of the artefacts is absent, but they are accessible through the cards and text of indexing, and thus the artefacts are both absent and present (Hetherington, 2004). In this way, as Hetherington (2004) argues, multiple absences and presences are assembled concurrently and in shifting ways (Callon and Law, 2004). The emergence of varying absences is interesting and relevant to abortion, and I account for these with method assemblage.

Law (2004) discusses out two distinct forms of absence. The first is 'Manifest absence', which refers to that which is absent but realised in its relationship to presence. So, the example of the holiday referred to earlier could be considered to be manifestly absent - it is not possible to bring this reality into presence, however, it is made manifest or visible by the holiday photographs. The second is absence as 'otherness', and concerns that which is absent due to the enactment of an inhibited presence: that is, an absence that is unable to be made manifest or visible. Otherness is an absence that disappears. Given the divergent articulations of the abortion-related pregnancy described in the previous chapter, the interdependent arrangements of absence and presence offer a rich means to explore complexities, and to follow the shaping and reshaping of professional identity within abortion assemblages.

A further thread to absence and presence requires an allegorical reading of events. Allegory, as Law (2004) suggests, involves representational possibilities that "makes manifest what is otherwise invisible" (p. 90). Instead of otherness, this allegorical art of 'reading between the lines' makes visible and holds together indirect relations, those that otherwise are unaccounted for and which do not necessarily cohere (Law, 2004; 2007, Law and Hetherington, 1998). The notion of allegory does not insist that multiple divergent realities need be forced into singularity, and in this way it allows space for ambiguity and ambivalence (Law, 2004).

An example of allegory that exceeds words but emerges through architecture is the case of the Alcohol Advisory Centre, in which a dilapidated building houses a treatment service for those with alcohol-related problems (Law, 2004; Law and Singleton, 2005). Law (2004) noted that "[w]e argued that organisational fragmentation and shortage of resources were reflected in this run-down building and the events that went on in it" (Law, 2004, p. 87). A street that "smells of poverty", "a nondescript door", a long flight of poorly carpeted stairs, no proper

meeting room, a disarray of pamphlets, clients files and half empty coffee mugs describe this setting (Law, 2004, p. 86-87). The description of the service that Law and Singleton (2005) provide, and their encountering of this setting, generated a reality that was not made explicit in conversation and "escaped the possibilities of language" (Law, 2004, 87). In this way, Law (2004) suggests "the disorganisation out-there (manifest absence) was being brought into presence and enacted by the premises themselves, or by our verbal but also emotional and aesthetic interaction with those premises" (p. 87-88). An allegorically responsive approach to identities opens up the possibilities for divergent representations of identity.

In the following sections of this chapter, I initially talk about boundaries, both physical (the gate at Lyndhurst) and conceptual (the notion of inclusion and exclusion), to begin to articulate professional identity and how particular identities may be made present and absent. I make use of my entering the gate at Lyndhurst to introduce this non-human actor mediation of 'molding' the identities of those who gather at this site. The process of gathering and the divergent possibilities that emerge at the border of the gate are articulated as an example of Star and Griesemer's (1989) boundary object - an 'object' that is shared between divergent groups that each hold their own representations. Later in the chapter, additional non-human actors such as a sphygmomanometer (blood pressure monitor), hospital bed, and rubbish in the carpark, are revealed to contribute to the formation of boundaries, membership and the assembling of identity. The gate, sphyg, hospital bed and rubbish act rather like Jerolmack and Tavory's (2014) notion of a 'totem', a device that assembles and mediates membership to various collectives.

Then, I argue that the assemblage of professional identity is mediated by the interactions between various human and non-human actors at the premises of Lyndhurst. The materials of the premises, such as furnishings and medical apparatus, that are made present, interdependently produce absences as this pertains to the dearth of quality materials and resources. The assemblage of materials or lack thereof juxtaposes and disrupts the intangible activities of care that Lyndhurst staff enact. Links can be made with the allegorical account of alcoholic liver disease by Law and Singleton (2003: 2005), where Lyndhurst performs similarly to the Alcohol Advisory service by 'making do' in order to provide a service, and, through the assemblage of human and non-human actors, produce incoherent and concurrent professional identities.

The notion of absence continues to be revealed in the following section where 'distancing' from abortion takes form in a number of ways. In this section, I show that in the interactions

following an interview, that the presence of a baby acts as a 'totem' that assembles a singular professional identity related to abortion provision where babies are made absent. At the same time, by bringing the association with abortion to the fore, the multiple memberships that staff of abortion provision hold are distanced from their identitiy as a 'whole'. When Lyndhurst staff are recognised outside of the workplace, and their association with abortion is foregrounded, this emerges as a form of 'interactional ambush' where Lyndhurst staff must ultimately reckon with the identity they have been ascribed (Jerolmack and Tavory, 2014). Conversely, Lyndhurst staff may obscure or 'other' their relationship with abortion provision in interactions where the professional identity they may acquire is unpredictable. This obscuring of professional identity both enacts the otherness of abortion provision and concurrently is mobilised as a means to enact agency and mitigate the prospective negative effects that may ensue in interpersonal relations. This distancing from abortion is not merely enacted by staff, but also by other health professionals who refer to Lyndhurst but are located outside of this immediate network.

The final section describes the unstable and contested professional identity of social work at Lyndhurst. Social work is viewed as an assemblage comprised of knowledge, qualifications, the role that is enacted, and the texts and tools that they combine with in order for social workers to *be* and perform the counselling that they are obligated by legislation to provide. This specific social work assemblage alerts us to differences between social workers and other professionals, such as medical staff at Lyndhurst who assemble with different qualifications, texts and tools. This section attends to the asymmetries of professional identity where social work is enacted in the margins of the dominant activities of abortion provision. Within Lyndhurst, social work struggled to assert a particular mode of counselling. The efforts of social work to establish a presence and stability within abortion provision was contested when divergent communities of practices took up 'counselling' and adapted this practice according to their own care practices. The introduction of a new medical abortion service provided the opportunity to reconfigure the social work role, since counselling, as a social work assessment, did not entirely succeed in making social work indispensable. In this way, a social work professional identity remains unstable. However, before we look at these things, we must enter the gates.

Material Mediators of Professional Identity

Boundaries, both physical and conceptual, include and exclude various actors to specific network arrangements. By following the process of how this occurs, it is possible to reveal how professional identity takes form or is disrupted. Material mediators, like the clinic gate at the border of Lyndhurst, are key to these arrangements. As are the premises at Lyndhurst, such as waiting rooms, through which professional spaces are assembled.

Boundaries - The Gateway

The entrance to Lyndhurst gathers different actors. Protestors, Lyndhurst staff, service users, and pamphlets all intersect at the gateway. Each of these actors encounter the gateway because of their associations with an ensemble of other actors, for a range of different purposes, and to engage in divergent activities - to protest abortion, to enter the work place, and to enter the site for abortion services. A tall forest-green corrugated iron fence runs along the boundary of the premises at Lyndhurst. A gate, steel, wide, half-height, and wire-latticed, is open. However, even in its openness it provides a boundary. This gateway itself marks a line of either being outside or inside of Lyndhurst grounds and mediates the inclusion and exclusion of various actors as members to this setting. The border of the grounds as a space that gathers and separates diverse actors and assembles specific affiliations is significant enough.

The gateway to Lyndhurst and the activities that occur here perform much like the concept of 'boundary objects' articulated by Star and Griesemer (1989)– an 'object' that is shared between divergent groups that each hold their own representations. In a more recent article expounding this concept, Star (2010) states that "Boundary objects are a sort of arrangement that allow different groups to work together without consensus" (Star, 2010, p. 602). To break the term down a little, the word 'boundary' as Star (2010) defines it, does not refer to a border per se but to a "shared space" (p. 603). In addition, 'object' refers to that which is enacted between groups – its materiality is not determined by its matter but by its action and process (Star, 2010). The gateway then, as Star and Griesemer (1989) indicate, is one of these "objects that inhabit intersecting social worlds" (1989, p. 393) or mediates, like Bowker and Star (1999) discuss, "multiple communities of practice" (p. 286).

Linking in with Jerolmack and Tavory (2014), a mundane object like the gate or entranceway, can play a part in 'molding' our interactions with others (p. 67). Like human actors, objects can be thought of as mediators that have the ability to "transform, translate, distort, and

modify the meaning or the elements they are supposed to carry" (Latour 2005, p. 39). Similar to Star and Griesemer (1989), Jerolmack and Tavory (2014) state that "Interactions with nonhumans, then, can be an important part of the process by which the social self is internalized, enacted, and sustained" (p. 65).

At the gateway at Lyndhurst, I am afforded, via my working role, membership to a group that permits me to pass through the gate. The protestors who gather on the street side of the gate may stand at its outer posts, they may touch the gate and weave their pamphlets through its wires, but they may not pass through. A sign inside the clinic gate that is attached to the outside of the hospital building indicates that trespassers will be prosecuted – a legal barrier to those who protest at the gate. This material actor is important in its associations with other actors who interact with the gateway by indicating that those who pass through the gate must have a specific reason for doing so. Like Jerolmack and Tavory (2014) argue "…relationships with nonhumans organize, not merely reflect, one's social position and relations" (p. 65). The fieldnotes presented below illustrate this argument:

> *I'm on one of my fairly regular coffee runs. I am walking back to Lyndhurst from a local coffee shop with two trays of coffee, one in each hand, nine lidded paper cups in total. I see there are three protesters on the gate. They are familiar - two mature women with their rosary beads on one side and a middle aged man on the other who is holding pamphlets. I walk past the women and I make a right-hand turn to proceed through the gate. I hear the man speak, "Don't kill your baby". I feel a surge of aversion followed by the internal dialogue, "do they not recognise me by now!" Usually I say nothing but today I look directly at him and simply state "I work here". I turn my head in response to a female voice as one of the women says solemnly with a furrowed brow "How could you?"*

In the absence of my photo identification card that is tucked away somewhere in my bag or on my desk, the gate mediates my identity.[51] I am an actor who has permission to move in and out of the premises freely. When I pass through the gate, this action marks this difference. The implications are that either I work there, or I am a service user. Accordingly, my identity is

[51] In contrast to the use of photo identification cards that enable staff at Christchurch Women's Hospital to move in and out of locked doors, the circulation of staff within the small team at Lyndhurst is more informal and without the modern technology that seals the doors between one space from another. Instead there are other material actors, such as the trespassing sign indicated earlier.

composed not only from the interactions that have taken place in the present, but also of those that are prospective and predicted by others who enter into these interactions.

When I am initially perceived by the protestors as a potential service user, the 'baby' is assumed to be within my female 'pregnant' body. I don't look pregnant, there is no visible evidence, as tends to be the case in early pregnancy. This assumption of a pregnant body mediated by my passing through the gate is what Law (2004) might refer to as a reality made "manifest" that "is otherwise invisible" (p. 90). My movement through the gate also brings into presence the wording, "Don't kill your baby". However, this set of arrangements that generate a pregnant body is an anticipated reality.

Like Jerolmack and Tavory (2014) discuss, the notion of a 'baby' acts as a totem that may "mold the social self by structuring how one will be perceived by others and constraining the possibilities for alternative presentations of self" (p. 67). In this way, the interactions we have with non-humans, like the gate at the border of Lyndhurst, may "mold" our interactions with other people where the "social self" takes form in other ways from what we might anticipate from those that we encounter (Jerolmack and Tavory 2014, p. 67). Thus, when I make my way towards the gate, and it is clear that I intend to pass through it, I have acquired a certain identity, the identity of a service user, by those who assemble outside of the gate to protest the activities that take place on the inside. The 'interactional hook' discussed by Jerolmack and Tavory (2014) disrupts my professional identity as a social worker at Lyndhurst when I have been coupled with the gate and my passage through this. Whilst I am aware that I may be linked to Lyndhurst because of my movement through the gate, the protestors have assembled my identity differently than I would assemble this myself.

Indeed, 'I' am not recognised. It is rather that a female body is observed. Despite my regular passing through the gate and across the line of sight of the protestors that gather outside, they do not see 'me'. They see a female body and a potential client. Initially, I am allocated to the collective of service users. When I resist this anticipated identity by disclosing that "I work here", my identity shifts from one anticipated reality to another - from someone who could "kill their baby" and may be dissuaded from doing so to someone who does 'kill babies'. In both my initial assumed identity as female service user, and then when I am established as a female staff member of an abortion service, I am linked with the metaphor of 'killer'. Any immediate action or evidence of doing so is absent. When I overlay this act with my admission, "I work here", my verbal cue aligns my membership to the collective staff of

abortion provision, whatever the role may be. This work is not met favourably. Indeed, a question is posed to me, "How could you?"

Assembling Professional Spaces

Whilst material mediators like a gate can assemble an anticipated identity and disrupt the professional identity, so too can the materials and spaces inside the gate in which work occurs. The premises at Lyndhurst are in contrast with a newly built Women's Hospital at another Christchurch location. Unlike the new hospital and its distributed array of services, Lyndhurst was not purpose-built for providing abortion services. Abortion provision made its place within an existing configuration of spaces. Whilst the spaces and materials were adequate to provide the services that Lyndhurst was assembled to offer, it is also the case that material mediators can disrupt professional identity when a service must 'make do'. We see this in terms of spaces of 'poor fit' and dated equipment and tools. These materials work well enough; however, they also 'act back'.

As part of the Canterbury District Health Board (CDHB),[52] Lyndhurst, whilst operating under the umbrella of the Women's Health Division, was a service that was geographically removed and separate from Christchurch Women's Hospital – connected but located apart from the other women's health services. Lyndhurst, the service, had not been incorporated into Christchurch Women's new build.[53]

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[52] There are 20 District Health Boards (DHB's) in New Zealand. These (DHBs) are responsible for providing or funding the provision of health services in their district.

[53] The original Christchurch Women's Hospital was located on Colombo Street in Christchurch and closed in 2005. At this time Lyndhurst was based offsite, on the corner of Montreal Street and Bealey Avenue, and continued to operate at this site until the 2011 Christchurch earthquake when Lyndhurst was relocated into the Christchurch Hospital. I have not been able to verify reasons for the exclusion of Lyndhurst from the Women's Hospital rebuild; however, communication from several Women's Health staff suggest a 'lack of space' and also the controversy of including an abortion service into the new hospital. Interestingly, in a speech by the Prime Minister of New Zealand at the time (who opened the new Women's Hospital), the relationship between buildings and providing quality health care was noted. An excerpt of the speech follows:

> *"In health, we know that buildings aren't everything. It's what happens in them which counts. But it certainly makes a huge difference to our highly valued health workforce to have modern facilities and state of the art equipment. There will be many fond memories of working at the old Christchurch Women's Hospital on Colombo Street. But alongside those memories will be the experience of working in the new hospital which represents best practice in hospital design. This matters for all who use the hospital – the women who give birth here and their babies, and the women who seek treatment here. Each one of them deserves the very best that we can provide in health care in New Zealand".*

While the environment at Lyndhurst was familiar in one sense, ANT sensibilities allowed me to pay particular attention to materials that comprised this setting. The wooden villa, trees, and rose garden of Lyndhurst presented a sharp contrast when I went offsite for social work meetings to the 'new' Christchurch Women's Hospital with its shiny surfaces and stunning art. Lyndhurst seemed dull and dowdy in comparison.

With the adoption of ANT sensibilities, I was made sensitive to differences between the two sites as I moved back and forth between the two spaces. In addition, because of this sensitivity, I noticed the way that one setting inevitably evoked the other. Linking to Law's (2004) method assemblage, it is in the gathering together of the 'dull and dowdy' socio-material relations at Lyndhurst, that the 'shiny' materials gathered at Christchurch Women's Hospital are made manifest through the connections that these services hold. Both sets of services function under the same umbrella, yet through their differing sites and materials, we are alerted to the presence of different realities.

There were times when I felt ashamed of the environment at Lyndhurst that women must enter into. The fieldnotes below include some of these observations:

> *My social work colleague and I are walking back to Lyndhurst from a nearby coffee shop. We walk through the gate into the car park. The building is to the left. "Someone really needs to tidy this place up" she says, "I try to pick up any rubbish when I walk in but just look at the weeds". The edges of the car park are framed with overgrown weeds that have captured the odd piece of paper or takeaway food container. The lawns are mowed but the garden each side of the path is a little unkempt. Sometimes the garden at Lyndhurst is beautiful. In summer the grounds are full of flowers – roses, peonies, dahlias and there are raspberries and cherries out the back. We put flowers on various tables at Lyndhurst and sometimes take bunches home. When is gets colder, the gardeners plant pansies at the entrance. However, today, prompted by my colleague, I look and see that the setting looks drab. The car park looks messy and neglected. What must it be like for women to come into this setting for the first time when the place looks like this?*

At Lyndhurst, incoming service users made their way through the car park and at the front door; they filtered immediately into the waiting room divided into three sections by pale

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https://www.beehive.govt.nz/speech/pm-opens-christchurch-women039s-hospital

muted green movable partitions. The first section was opposite the entrance, and two other sections were located to the left with a pathway between these that led to the rest of the building. Down this pathway, a burgundy swinging door with a glass pane taking up the top half of the door enabled a view further down the corridor.

In the waiting room, within the partitioned sections, dusky pink chairs are arranged – six or so chairs in each section. Graffiti is carved into the wooden arms of some of the chairs. The grey/brown carpet is stained here and there. There is one tall but rather spindly looking plant with sparse green leaves located to the left of the entranceway. I realise that I have never seen anyone water it. Is it plastic? The décor is tired and shabby.

The partitions attempt to divide up the waiting room into distinct private spaces, yet, privacy and private spaces are hard to come by for those who have come to enter Lyndhurst as service users. As a colleague notes:

> I49: The waiting room's appalling. There's no confidentiality. It's a bit like a railway station. People coming and going and walking through backwards and forwards. It's a sensitive area and I don't think that's taken into account. All those little screen things between seats, it's very difficult to have any sense of confidentiality and respect coming into that I think.
>
> (Interview 49)

As noted, Lyndhurst was not a purpose-built site for a termination of pregnancy service. The site in the past had been used as a residential care setting for older persons and as a maternity hospital. The layout of the building involved some large rooms that were inefficient in terms of space considerations. One of the counselling rooms I used in the latter part of my time at Lyndhurst was very large, about the size of two smaller rooms, as was the staff tearoom opposite the kitchen. Moreover, there was some awkward placement of specific rooms. The sluice room was barely concealed from the view of a second ad hoc waiting area in a wide hallway where chairs were lined against the hallway wall. There was an old screechy radio that played in the corridor to mask the noises of abortion provision, whether this is 'inappropriate' laughing or the tears that may arise in the recovery area, or the occasional clatter of medical instruments from the sluice room. In addition, the smell of toast, the offering to service users following a procedure, wafts through the corridors. A service user explains:

> I33: …you're right in the guts of it all really, all the instruments clattering and the toast burning and it's just all, it's just not, it's…the Feng Shui is really wrong

> [laughter]… Lyndhurst is shabby – it devalues the patients and doesn't reflect the hearts of the workers…
>
> (Interview 33)

Identity is assembled not only by that which is attributed to the person, but by the *materials* that people assemble with. The premises are shabby, and different spaces, sounds and smells encroach upon other spaces that are coordinated poorly together. Much like the point Moser and Law (2003) make, identities are made relationally. These material actors, instruments, burning toast, inadequate spaces, disrupt the efforts of staff to assemble a professional presence. Yet, alongside this, staff must assemble professional identities and thereby disrupt the latter method assemblage.

> I16: I mean they can't believe that we laugh and that we smile, we might crack a joke, and just accept them. And I say to some of them "this is just what we do here, it's our job", not being flippant and saying it's only a job, but this is our job, to look after women having abortions, to make it as easy for them as we possibly can, and to make sure that its safe and that they've got a secure place to have it in and that there are all the supports there that can be available, that's what our job is.
>
> (Interview 16)

The gathering together of materials, spaces, and actions at Lyndhurst provide an example of *allegory*, in that several realities made manifest and are held together whilst at the same time they do not necessarily cohere (Law, 2004; 2007). Law (2004) talks about the Alcohol Advice Centre on Castle Street, a community-based alcohol information centre in a similar way to the representation of Lyndhurst as shabby and ill-suited for the service it provides. He states that manifest absence "was being brought to presence and enacted in the premises themselves, or by [our] verbal but also emotional and aesthetic interaction with those premises" (Law, 2004, p. 88). The Alcohol Advice Centre impresses upon these researchers "An impression of make-do" with its indistinct, shoddy building and dearth of resources (Law and Singleton, 2003, p. 245-6). Much like the Alcohol Advice Centre, at Lyndhurst there exists a presence of absence that hangs heavy.

On one hand, professionals at Lyndhurst engaged in innovative practices and with new technologies of care, such as that articulated more comprehensively in the following chapter with regards to a new medical abortion service. On the other hand, staff at Lyndhurst provide their services by 'making do' with materials that at Christchurch Women's Hospital have lost

their worth and have been made redundant. The older equipment such as brown-end beds, old sphygmomanometers (blood pressure monitors), graffitied chairs, partitions alongside the presence of the weeds and rubbish in the carpark, were tangible contributors to describing the service, staff and clients by the association with these actors. The following staff at Lyndhurst express this:

> I43: Why does Lyndhurst get the shit of shit of everything? It's still a service; it's still in the CDHB, why do they get beds that they eliminated at Christchurch Hospital five years ago. There are no old beds at Christchurch Hospital. None. When I say old beds I mean brown end beds which they've got at Lyndhurst.
>
> (Interview 43)

> I28: …we're like the poor relation; we're across the street - forget about them. I mean look at the equipment, patients can't believe it, the old spyg's to do their blood pressure, "oh, I haven't seen one of those for years", it should be in shanty town shouldn't it?
>
> (Interview 28)

The staff member above argues that Lyndhurst is "…still a service; it's still in the CDHB…". Yet, the shabby environment and the absence of up-to-date materials denotes that the human and non-human actors of the CDHB are asymmetrically present as part of Women's Health service provision as a whole. Within the CDHB, but in juxtaposition, Lyndhurst and Christchurch Women's Hospital afford two versions of a reality that do not cohere (Law, 2004).

For Singleton and Michael (1993), incoherent realities are present in their case of ambivalences within the UK Cervical Screening Programme. Here, two realities are presented – one that asserts to the value of the Cervical Screening Programme, and a second that attunes to the uncertainties of GPs who concurrently doubt and uphold this programme. Similar to Singleton and Michael (1993) in their analysis of the cervical screening programme, the services at Lyndhurst are upheld and doubted – they are both a part of and apart from women's health services. Likened to the example of Singleton and Michael (1993), the services at Lyndhurst "at once occupy the margins and the core… [they are] both insiders and outsiders" (p. 232).

As van Berkel (2004) has argued, professionals in abortion provision may be presented with conflicting messages about the work they do from institutions. There are messages, van Berkel

(2004) suggests, that: "we believe in abortion enough to provide the service and we will pay you to do the work, but we certainly do not want anyone to know about it" (p. 11). A senior CDHB staff member speaks to the notion of ambivalence below:

> I36: It's sort of like we've got the service, we do it but we don't talk about it and we don't develop it. We're just sort of quietly in the background, in the backwaters getting on and doing it like it's some disabled child that we don't want to present in public. You know it's a horrible, kind of really archaic way of delivering a service and it's the thinking, the culture behind it, is completely out of sync with other services.
>
> (Interview 36)

Lyndhurst is not a service that will readily be found by walking into the hub of women's health at Christchurch Women's Hospital, yet it is included within the network of women's health provision. It is offsite and separate – both within the network and absent. Lyndhurst engages the materials that have been discarded from the new hospital and makes do with 'recycled' spaces. Moreover, to use a term from the actor above, it sits quietly in the "backwaters" of service provision as a whole.

Professional Identities: Enacting presence and absence together

For Law (2004), absence and presence are not mutually exclusive, sealed off from the other, but rather they are mutually constitutive. Law (2007) has noted that if we sought to describe the world completely, we would ultimately fail, as the description we offered would always be incomplete. For something to come into presence, for example, by articulating it, inevitably means that other articulations of the same thing are made absent. In this way, the production of presence and absence happens at the same time - presence and absence are always enacted together. If we think back to the example of the gateway at Lyndhurst, and how the gateway mediated a version of my identity, then we can see that concurrent presence and absence is generated. When my passing through the gate brought into presence the notion that I am a prospective service user, at the same time my social work identity was made absent.

By being present and active within abortion provision, staff at Lyndhurst assembled with a variety of materials and spaces. Further to the non-human actors identified earlier, wearing uniforms, holding medical apparatus and patient files, and by occupying various spaces and

performing particular roles and tasks, staff at Lyndhurst, inevitably, acquired an identity because of this involvement. A focus on this identity formation, however, meant that the multiple memberships that staff held that involved various other materials, groups, spaces, was overtaken. This was particularly true when a 'singular identity' of working in abortion provision was pulled to the fore and was assembled *for* these actors by others, rather than *by* these actors on their own terms. One mode of managing this 'identity reduction', the way in which staff at Lyndhurst were reduced to their work in abortion provision, was to make their connections with abortion absent in their communication with those outside of this immediate networks – both their colleagues and supportive family and friends. In this way, staff at Lyndhurst intentionally enacted a process of 'othering' in order to manage the production of their identity, to protect positive social connections with others they encountered and to resist adversity and disruptions to their professional identity. The othering of a relationship to abortion provision is also revealed by looking beyond the premises of Lyndhurst to the connected health settings that refer to the service. By following these connections, it will become clear that a further form of othering involves an assembling of distance from the practices of Lyndhurst, even within overlapping spheres of professional work.

Assembling a 'Singular Identity'

The presence of an abortion-related identity for Lyndhurst staff generated an apparent singular identity – a paring down of the identity of staff, where their affiliation to abortion provision was foregrounded, and where other aspects of their identity were at the same time overtaken and made absent. In the following example from my field notes, I briefly note an arrangement where I have been interviewing a past service user for this study. The pleasantries following this interview offers an illustration of this notion of a singular identity that emerges from my relationship to abortion provision:

> *At the end of the interview, the woman hands me her baby and says, "Here you go, have a cuddle, you wouldn't get much of this would you"*

In the statement above, there is an implication that the act of holding a baby is something that is lacking from my world. My identity for the past service user above has been shaped by the 'treatment' that Lyndhurst provides and my active role as part of this (Nathan, 2009). Even though I am meeting with her in my research role, she has assembled the 'me' in front of her as a member of staff at Lyndhurst, whose realities concern the ending of pregnancies and thus the absence of the babies for whom hers represents. This perceived gap in the assemblage of

my professional role moves the past service user to hand me her baby, a proxy for the babies that, because I work at Lyndhurst, I "wouldn't get much of…". In this way, her baby is an entity that plays a part in reconciling the perceived deficits in an identity assembled for me, as a staff member at Lyndhurst. The baby becomes a 'totem' that mediates the formation of a group to whom I am deemed to belong (Jerolmack and Tavory, 2014; Latour, 2005).

However, *this* baby, as a proxy or totem for babies universal and for those who include babies as part of their worlds, takes a form that is other than itself. In this way, the baby becomes symbolically objectified. This is not to say there she is less human, but in the interactions described, the baby acts much like the objects that proliferate social worlds, that play a part in gluing aspects of the social together. These 'objects' that are part of social interactions can "mold" social identity by creating a 'situational self', relevant or not (Jerolmack and Tavory, 2014). Consequently, this may displace other aspects of identity and may disrupt or discredit this identity or the self as a whole (Jerolmack and Tavory, 2014). Further, like Star (1991) and Star and Griesemer (1989) discuss, objects occupy many worlds at once. Objects may cross the boundaries between one world and another, and in this way, occupy multiple social worlds. This is the case when these objects are articulated according to their absence, such as the babies that are absent at Lyndhurst and that the informant's baby stands in for - a baby/object that has been made present to counter absence.

For Lyndhurst staff, this type of interaction was not an isolated occurrence. In a broader, informal discussion amongst staff at Lyndhurst, the following comment emerged, "Don't you hate it when people shove a baby at you". Staff were talking about coming into contact with past service users in the supermarket and other unlikely places where this type of interaction, the foregrounding of babies, may occasionally take place. The presence of a baby in this set of relations acts as a mediator or "interactional ambush" by imposing a social identity outside of a situational identity that the recipient must ultimately reckon with (Jerolmack and Tavory, 2014).

Like Jerolmack and Tavory (2014) argue, membership is shaped and subject to boundaries imposed by others, and consequently, this constrains the capacity, in this case for Lyndhurst staff, to hold membership to other groups. So, even in the mundane activities of shopping for groceries, the individuals who work at Lyndhurst are not co-present as mothers, friends, cheese lovers, wine tasters, stage performers, dress makers, touch rugby players or whatever, nor their profession as nurse, social worker, doctors or otherwise, but they are inextricably and homogeneously identified by their association to abortion provision.

Outside the arrangements of Lyndhurst, staff can be all of these previous things. They are not visibly linked to the building, they have shed their uniforms, have exited offices and operating theatres, and are not walking down the supermarket aisle pushing a trolley of linen or medical apparatus, holding a patient file, pills, or sphygmomanometer - the tangible things or 'totems' that work to assemble and order membership and a professional identity in the clinic setting. Yet, their membership has been formed based on the recognition of their face and the link that has been made to Lyndhurst. For Jerolmack and Tavory (2014), a wallet is the non-human actor that disrupts the persona of the authors who are sitting at a restaurant table. The presence of the wallet and the visibility of cash displaced the ability for one of the authors to shrug off or rebuff the panhandler with the common claim in this situation of not having money. Because of the presence of a wallet, the author was tied to reworking their performance as a person who had money but would not part with it. The face of the staff member at Lyndhurst operates in much the same way as the wallet, an 'interactional hook', where the staff member cannot 'pass' as just another shopper but must attend to the disruption to their persona that recognition mediates.

Enacting otherness

Whilst a connection with abortion provision may foreground this aspect of identity for staff at Lyndhurst, in different arrangements, this part of their identity was also pushed away. For staff at Lyndhurst, one mode of managing varying modes of 'identity reduction' was to make their connection with abortion provision absent in their communication with those outside of this immediate network.

These accounts alert us to what could be viewed as a controversial thread of abortion, a 'secret society' that is not talked about. By not talking about their involvement with abortion, staff at Lyndhurst enact a version of otherness – making absent their involvement with abortion provision because its presence is unable, for various reasons, to be made visible or manifest. Of the possibilities that Law (2004) presents for how otherness takes form, the mode that applies most directly to that of abortion provision is otherness as an absence that is hidden and repressed (p. 144). Lyndhurst staff enacted this otherness by 'hiding' and 'repressing' the work they do:

> I52: …we don't openly disclose where we work, we don't openly discuss what we do…you know, it's like being spooks, no one else knows. On the surface of it we go to work in a health service but only the people who work under our roof know what

> special and important work we do. So, I mean that's bullshit and we know that but that's how you can feel.
>
> (Interview 52)

Like van Berkel (2004) and Simmonds (1996), I found that Lyndhurst staff employed strategies of concealment regarding their involvement with abortion services. In van Berkel's (2004) study, identity was linked with professional occupation where, for those working in abortion provision, practices of concealment and silence mitigated adverse social, emotional and physical effects. Similarly, in the account above from this study, the staff member above likened herself and her colleagues to a 'spook' - perhaps alluding to work and actors that are not articulated into presence.

It appeared that it was a regular practice of Lyndhurst staff to make absent their association with abortion provision in their interactions with other actors. In my informal conversations with Lyndhurst staff, and in the interview data, these actors expressed what they did to obscure their involvement with abortion provision. Often this involved bringing other actor-networks to the fore and bringing these into presence in order to maintain the absence of abortion work. The broader umbrella of Women's Health afforded an alias to the precise location and the specific work that Lyndhurst staff 'really' did and a preference to be part of the larger women's health network. While at the time Lyndhurst was located offsite from Christchurch Women's Hospital, this wider actor-network did in fact encompass Lyndhurst. The ambiguity of human actors' 'work' was enacted by a range of non-human actors: CDHB swipe cards, training activities, pens, note pads, access to pool cars, and so on. The 'black-box' or network consolidation of Women's Health acted as a device to obscure staff involvement with abortion and dissolve this membership within the indistinct realm of women's health services.

> I1: I never really talked that greatly [pause] about where I worked. If someone asked me about where I worked I said "Women's Health"…quite often, when you said you work in Women's Health, particularly if you're talking to men, they don't want to know. [Laughs] Quite handy really…you really don't know what sort of effect you're going to have when you say you work in the area of abortion, so you're probably a little more vague.
>
> (Interview 1)

These practices of articulating absence do not make a controversial identity benign, but they may afford a means for staff to forge protective boundaries between themselves and others. Lyndhurst staff talked about concealing their membership to abortion provision in a number of situations. This included protecting the pleasure and leisure of social time out with others. It also involved alleviating less pleasurable situations, such as getting into any debate about the rights or wrongs of abortion, prospective backlash because of their participation in abortion provision, and hearing personal abortion stories at times when they were outside of their professional role. The practice of staff to make absent their involvement in abortion provision is a means of what Star and Strauss refer to as "silent resistance", a strategy to take care of oneself (1999, p. 18). It was easier to manage social interactions when abortion assemblages were excluded. In this way, staff protected their personal space, and often for good reason, as the actor below shared in an interview:

> I44: There was one guy I was seeing and I had said I was working in women's health and he asked about it and I ended up having to tell him where I worked because he turned up at work one day and of course I wasn't there. He found out where I was working and that was it, it was over. So, yeah, I'm kind of cagey until I get to know someone really well before I tell them where I work.
>
> (Interview 44)

Abortion work has been noted to be morally and ethically loaded and potentially "dishonourable" for health professionals (van Berkel, 2004, p. 7). In addition to practices designed to protect "social time", workers associated with abortion provision often keep their work secret due to concerns of safety and stigmatization for themselves and the people close to them (van Berkel, 2004; Todd, 2003). By making 'abortion work' absent, staff also made absent the controversies associated with their work. In this way, staff in abortion provision ameliorated unexpected disruptions or discrediting of their identity by others whose perception of abortion was uncertain (see Jerolmack and Tavory, 2014).[54] In any given interaction, Lyndhurst staff made a choice about how they respond, what they say, how much they revealed. By making absent their role in abortion provision, staff in this field also

[54] Rather than the risks associated with overt anti-abortion violence apparent in some international localities (Todd, 2003), in New Zealand issues regarding concealment are more related to stigma and the sensitive nature of abortion.

negotiated a space to shed their otherness. A short quote from a former staff member of Lyndhurst is particularly illuminating in this regard:

> I15: I often think about it [being part of abortion provision] and it's funny to be out of it and be thinking about it as a normal person…
>
> (Interview 15)

Here, the work that is done at Lyndhurst is described as sitting on the periphery of what might be the common activities and the usual practices of health services. In response, Lyndhurst staff deployed the activities of talk to disguise the activities of work. This manufacturing of absence, then, may be a strategic practice. Star and Strauss (1999) argue a similar point. For Star and Strauss (1999), the term invisibility rather than absence is engaged to articulate the negotiations of identity for those participating in domestic work:

> "…some invisibility is a strategic managing of parts of oneself that are inappropriate or undesirable in the workplace – and this may be positive as in autonomous control of the self, or negative, as in hiding shameful aspects" (Star and Strauss, 1999, p. 23).

As Star and Strauss (1999) premise, the motivations for mobilising invisibility and the strategies for doing this may have positive or negative underpinnings. For staff at Lyndhurst, their practices of mobilising of absence oscillated between these. By enacting absence, Lyndhurst staff were agents in activating the privacy of their subject self and managing how others might assemble their identity. They employed discretion as a subjective practice where discrete choices are made to make present or absent their membership to abortion provision (Moser and Law, 2003).

Because of their understandings of abortion networks, the absence that Lyndhurst staff enacted was purposeful. It was a means for staff to mitigate the negative effects that might result from their membership to abortion provision. I noticed that this was the case whether the negative effects were enacted on the staff themselves or upon those who they were interacting with. Because, further to the preserving of the self, enacting absence is also a means of protecting others. The following quotes attest to this:

> I19: I don't want to upset people and hurt their feelings, so I tend not to come out with it straight away…
>
> (Interview 19)

I47: …if I regard them as ok or open or safe or not going to get upset I generally say.

(Interview 47)

The making absent of a professional identity in abortion provision was not a dead-end acquiescence but a strategic compromise on the part of staff at Lyndhurst that took into account the consequences that might ensue. It was not absolute nor predetermined, but messily cultivated in the moment and in the relational work with other actors. For Lyndhurst staff, by enacting the multiple qualities of their identity and backgrounding their involvement in abortion provision, staff at Lyndhurst sought to exert agency in the production of their identity.

Assembling Professional Distance

The tensions and human actors' distancing from abortion did not merely arise from intimate interactions, but in and through the wider professional connections and networks that Lyndhurst staff were part of. In this study, health professionals connected to abortion provision may make absent their relationship with abortion provision, even when this service occurs in overlapping professional spheres of work. As Cassie (2006) has argued, nurses, doctors, and other health professionals are just as mixed in their grappling with abortion as other members of society. On one hand, as Cassie's (2006) participants mention, health professionals or those close to them may make use of abortion services, yet professionally "they don't want to know about it" (p. 9). The following interview extract from a nurse from a community health service articulates this tension:

I41: … I understand their [the patient's] rationale or motivation for doing it or making that really difficult decision. If I stop to think about the reality that babies are killed or their life is ended then that doesn't feel comfortable to me, um, because I wouldn't want to end anybody's life, you know, no matter how many minutes or weeks the pregnancy, however my sense is stronger with the here and now of that option for them…I think my division is that I'm distanced by being physically apart from where it happens and the persons emotional state and my ability to support that by offering the options available is where I can be maybe a little removed from it, where as if I had the option of performing it, then maybe that would be something I wouldn't do.

(Interview 41)

The excerpt above illustrates the tenuous relationship that health professionals may have with abortion networks. Similar to Singleton and Michael (1993) and their account of the

ambivalences that thread through the UK cervical screening programme, the relationship that the community-based nurse above has with abortion moves in different directions.

The nurse above articulates that she understands what might underpin an abortion decision for service users. However, the enactment of this reality is uncomfortable. As she states, she "wouldn't want to end anybody's life, no matter how many minutes or weeks the pregnancy" (Interview 41). Being "maybe a little removed from it" is enough in her terms to be separate from this act (Interview 41). In this way, whilst this nurse might make a referral to Lyndhurst, the enactment of abortion occurs at another location where work occurs that perhaps, she would not do. The geographical distance mediates the absence of abortion from her professional identity. The use of the word "maybe" however, perhaps leaves this rationalisation hanging. Allegorically, to follow Law (2004), what the nurse makes absent from her professional identity, the performance of abortion and 'the' reality that potential lives are ended, is generative of a further reality for the professionals that perform abortion at Lyndhurst without directly saying this. As Law (2004) suggests, allegory "makes manifest what is otherwise invisible" (Law, 2004, p. 90).

Allegory, as Law (2007) suggests, "is the art of meaning something other than, or in addition to, what is being said" (p. 603). Similar to the more commonly used 'reading between the lines', I found allegory to be evident in the tension between the established presence of the service and the diminished professional status of those who undertake the work.

O'Donnell, Weitz and Freedman (2011) have noted how within professional circles those involved in abortion provision encountered "an absence of acceptance" about what they did, an avoidance in talking about this work, or responses that implied abortion work was distasteful (p. 1360). An example of this included a comment that a nurse received from another medical professional receiving abortion services who was surprised that staff were "so professional and clean" (O'Donnell, Weitz and Freedman (2011, p. 1360). Making a link to Law (2004), this latter comment brings into presence the surprise of cleanliness and professionalism, and concurrently draws attention to what was not put into words - that the absence of these qualities was what was expected. For me, I recall a family member asking me when I was going to get a "real social work job". It was as if this work that I did within an abortion provision did not constitute 'real work' and was not valid when measured against some unknown standard. Staff at Lyndhurst reported similar interactions that related to their professional identity:

> I20: …I've got a friend, I bumped into her not so long ago, and I always thought she was fairly liberal…she said "how can you work in a place like that" she said.
>
> (Interview 20)
>
> I52: …I feel quite judged by my decision to work at Lyndhurst by my peers, by people I don't know very well…That there's something unsavoury or there's something not productive, not creative, those sorts of feelings about the work I do.
>
> (Interview 52)

Both staff members above noted a perception of deficit with the work that they undertook at Lyndhurst. The involvement in abortion provision does not bring into presence a professional identity that is 'real', 'productive', or 'creative.' Moreover, a professional identity that is grounded in skills and competency is absent and assembled as a 'non-reality' (Law, 2004).

When we follow elements of Law's (2004; 2007) method assemblage, we can see that that for some human actors, professional identity is excluded in a particular way, and done so in a way where this exclusion is not acknowledged. So, for example, the staff member in Interview 52 relayed that she had been asked "couldn't you find something more productive to do?" when she disclosed her involvement in abortion provision. What is not made present and acknowledged in this sort of expression is the perception that the work in abortion provision was deemed "unproductive" by the person the staff member encountered. Yet, whilst this 'unproductive' reality is absent, it does not disappear. By 'reading between the lines' the staff member is aware of what has not been said, and makes this clear in the quote about feeling judged.

(Re)configuring Professional Identity: Social Work in Abortion Provision

Professional exclusion occurs through a dynamic set of arrangements. Organisations, knowledge, family, the economy and technologies, as Law's (1992) earlier work claims, are effects that are generated through these actors, or heterogeneous "bits and pieces" of the social, and how they combine (p. 855). This is useful to have in mind when it comes to thinking about social work. Although social work may be talked about as a single actor, and

indeed it comes to look like a single actor, it is made up of an assortment of people and things – of different 'actors'. Qualifications, professional affiliations, service documentation, identity cards, office spaces, chairs and a multitude of other tools enable social work to be enacted. In this way, 'social work' is a network consolidation – a professional identity that is comprised of an assemblage of human and non-human actors.

The professional identity of social work was highly contested at Lyndhurst. A focus on the way in which the task of counselling is assembled within the social work role is key to understanding this. In this study of abortion, counselling was found to be a site of professional disputes. Part of the disputed nature of counselling can be traced to how it was configured within different actor-networks. Moreover, it is not just how counselling was configured within different actor-networks that is contested, but that counselling circulates *across* various professional memberships who take this practice up as their own and assemble their own counselling actors and practices. Different actor-networks, such as nurses, and community counselling services, tussled over what counselling was and who might perform its activities. Through these disputes, different versions of counselling were enacted and overturned both inside and beyond the premises at Lyndhurst.

This task of counselling that social workers undertook was located outside of the standard network of abortion provision that is concerned with efficiency and time. In this way, I show that counselling is a profession on the margins of the medical work that dominates this setting, and in this way it was othered. In order to enter the stable network of abortion, counselling was reconfigured where the actors and tools that underpinned this work are backgrounded in favour of new practices and wording – a psychosocial assessment, a compromise in an effort to maintain presence.

Counselling controversies and configurations

Counselling as part of an abortion assemblage did not merely 'belong' to the social work professional identity. As will become clear, social workers at Lyndhurst, nurses, and community counselling services assembled different versions of counselling that are linked to the professional memberships and configurations. Moreover, various non-human actors are key to how these variants of counselling take form and to the drawing of boundaries between different professional memberships. Abortion legislation that mediates the presence of counselling, specific social work qualifications, professional affiliations such as membership to the Aotearoa New Zealand Association of Social Work (ANZASW), Standards of Practice of the

Provision of Counselling (1998), pregnancy counselling training, texts, offices, and telephones, may all be present or absent as part of different counselling configurations.

The varying tensions about who should do counselling, what counselling should look like, and where this should be done, relates quite readily to the concept of 'boundary objects' (Star, 1988; 2010; Star and Griesemer, 1989). Revisiting this notion and the work of Star and Griesemer (1989), "Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of several parties employing them, yet, robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual site use. These objects may be abstract or concrete" (p. 393).[55]

As a boundary object, mutable versions of counselling unfold across divergent communities of practice. Within and beyond Lyndhurst, counselling is loosely structured and often adapted when employed by diverse groups: an abstract object - but more tightly articulated and concrete in its use by specific memberships, such as the social workers who performed counselling tasks at Lyndhurst.

A nurse at Lyndhurst illustrates the notion that counselling may be taken up and adapted by different professional groups:

> I1: You know even from the nursing point of view let's face it, the counsellors do a fabulous job, you guys do a fabulous job, but, you know, part of our job is that counselling role as well, on a different level, well not that different, well there is that difference in that we're not trained in that [laughs] but there is a counselling role – it's a real hands on role and there are times when people need you to just sit with them and just hear them out.
>
> (Interview 1)

Above, while the work that social workers do is valued, social work appears to assemble a different sort of 'professional' reality than that of the medical staff. As described above, counselling was considered to be integrated into nursing practices and trust in social workers as 'authorities' in counselling held little weight in this setting. In noticing this, I suggest that

[55] The emergence of this notion arose from the study of a museum where bird specimens were found to hold different meanings for both amateur bird watchers and professional biologists. Whilst the meaning attached to the 'same bird' differed according to these laypersons and experts, enough commonality was afforded for this object to be recognizable across these divergent worlds.

counselling is an example of allegory as it is a circumstance of "contested authority" (Law, 2004, p. 89).

Having considered the notion of counselling in relation to allegory, it is clear that I can use ANT sensibilities to link in with the notion of a boundary object in the way that Star and Griesemer (1989) unpack it. As a boundary object, the action of 'counselling' in the quote above appears to be located *between* 'medical' and 'social' worlds, and is taken up and adjusted by the nurse above as part of her nursing activities. As the nurse articulates, the counselling she employs is "not that different" except for the fact that nurses are "not trained in that". Nurses do not have the qualification that is part of the counselling network at Lyndhurst – within this network, being 'trained' is imperative to acquiring employment as a social worker.[56]

I note that when counselling is assembled by other actors, such as the nurse above, the backdrop of social work training drops away. Instead, counselling is reconfigured as something else. The nurse articulates this counselling component as a "real hands on role" where people need you to "just sit with them and just hear them out". However, the nurse wears a uniform, holds different qualifications, carries and uses various medical tools, and occupies different spaces within the setting at Lyndhurst, and these elements in turn configure counselling differently.

For the nurse above, counselling is referred to as a form of engagement – "hands on" but instead of hands and medical tools that focus on the bodies of service users, the ears are engaged to listen to women who enter abortion provision. The voice of the woman, her account, her story is what is taking primacy in this "counselling" role that the nurse enacts whilst the social work counselling 'toolbox' that is comprised of not only the voice of women, but a myriad of other actors, is displaced. While talking and listening practices are very much part of integrated care, that medical staff *do* counselling, and occupy this hybrid space, was not agreed upon by social workers.

> I52: …it comes up often in multidisciplinary teams, "why don't I do the social assessment, I've got the information here" and what I say to nursing staff is look, it's exactly the same, I can read the instructions and I can take blood pressure and I know

[56] To present an interesting anomaly, there were no 'counsellors' employed at Lyndhurst – there were social workers that provided counselling as part of their generic skill base, or appropriated counselling to follow the notion of a boundary object. Indeed, it is likely that those who have trained specifically as counsellors have their own ideas about the authenticity of this role

> how to draw up a syringe and I can give injections, I can do those things, the point is that I can do those things but I'm not trained to do those things. I don't have the certificate that says I'm the right person to do those things, it's not my role to do them. And when the person has a reaction to the injection given in a particular sensitive site or the drug was incorrect or whatever, I don't know what to do next…So when you ask nursing staff "if this occurred, what would you do next" they'll say "I have no idea". Again it's that whole understanding that you don't place your personal judgment or values onto another person, understanding that a human being has all the answers within them, they just need sometimes some understanding and support, some ability to reflect and reach those decisions. Nurses aren't trained to do that.
>
> (Interview 52)

Abortion legislation, professional standards of practice, professional affiliations, and qualifications, are all documentary 'hooks' that social workers rely on to articulate and authenticate their role (see Jerolmack and Tavory, 2014). However, we can also read this reality allegorically as "circumstances of contested authority" (Law, 2004, p. 89). For example, the *Standards of Practice of the Provision of Counselling*, and also membership in the Aotearoa New Zealand Association of Social Work (ANZASW), point to some sort of authority and legitimacy to the counselling at Lyndhurst. But, this notion only works if other actors, Lyndhurst staff and community counselling services, agree to this representation.

Linking again to the idea of counselling as a boundary object (Star and Griesemer (1989), counselling may be thought of as a common object that sits between groups, like in the example of the nurse who employed her articulation of counselling as part of her work. Other groups may take up counselling because it is an arrangement that is rather 'sketchy' and 'ill-structured' when it is enacted as a common object. Because counselling lacks the durability as a fixed professional practice that has authority only within certain spheres of work, other groups are able to pick this up and tailor 'counselling' for their own needs whether they are medical or social actors, professionals, or laypersons. An actor from a women-centred community agency offers her account of this below:

> I3: I mean here we don't have a formal set up, you know we don't have someone come along formally to I guess enter into a counselling type relationship, it's more an on the spot thing so it's a, probably a smaller version of what you do but you can do quite a bit in a small time to help people examine where they're at.

(Interview 3)

Outside of the 'formal' counselling set up that the above actor refers to, this agency employs its own version of counselling - 'counselling-type relationship'. Other community settings, offer further variants within a particular structure and context that is tailored by this group. An example of this is articulated below:

> I4: We're a 24 hour counselling service, counselling is a little bit of a broad term because we are not trained counsellors, but we've done a comprehensive 12 session course on pregnancy counselling.
>
> (Interview 4)

As Allanson (2007b) argues, pregnancy and abortion counselling that is conducted independently of abortion provision is often considered less credible by abortion providers (Allanson, 2007b) or as a strategy employed by 'anti-choice' actors to dissuade prospective service users from pursuing abortion as a pregnancy outcome (Cannold, 2002). At Lyndhurst and several long-standing community women-centred organisations, this specifically concerned a distrust of community groups with the 'pro-life' or religious associations. The term 'false providers' is one of the ways that these latter groups are described as in that they are thought to provide false information, block access to, and perpetuate myths about abortion provision (Allanson, 2007b). The ascribing of this notion of 'falsity' is an effort to secure a specific reality or 'purity' about the nature of counselling that those in abortion provision uphold. At the same time, this notion refutes the lay efforts of those whose enactments of counselling conflict with abortion providers.[57]

However, as became evident in the course of this local study, the counselling at Lyndhurst acquired its own sceptics. As Law (2004) discusses, those who may on one hand be deemed to be "sources of authorised knowledge", such as how social workers at Lyndhurst may assemble themselves, may also encounter laypersons who distrust the reality that these "experts" present (p. 89). There existed other modes of counselling beyond that provided, and counsellors who contested their practice. The following quote, as part of an interview between a community pregnancy counsellor and myself, draws attention to this.

[57] Similarly, as discussed in Chapter 3, Latour (2010) argues that actors may invert the claims of others to uphold their own factishes all the while obscuring the production of their own realities.

> Letitia: I wondered if there were some similarities, like my role is a social worker/counsellor at Lyndhurst and there must be some similarities with what we do and some contrasts as well.
>
> I4: I think there would be many contrasts. We are there never to make up clients minds for them and we like them to be fully informed, so when people ring us and say "I want an abortion", really, we would, if they were willing, give them the alternatives.
>
> (Interview 4)

The lack of consensus between groups is one of the elements of the boundary object (Star and Griesemer, 1989; Star, 2010). The lack of consensus between groups who enact the 'object' of counselling (Lyndhurst and the pregnancy counselling service) was revealed in this arrangement. Whilst Lyndhurst social workers would argue that, they in fact did not make up clients' minds for them and that they sought to fully inform clients, the community counsellor implies disagreement with this.

As Law (2004) explains, laypersons, like the actor above, may be sceptical of the 'expertise' that is claimed by those who hold particular authority and may question the interests that sit behind expertise. The community counsellor in the interview above makes it clear that the mode of counselling at this service is in contrast to that which Lyndhurst provides. The allegorical implications of reading the above quote is that we are made aware of how this actor perceives the counselling service at Lyndhurst by attending to what she does not say directly. By talking about the service she is part of and what they do, by contrast, she implies what she feels Lyndhurst does not do. The issue of clients being fully informed is of concern here in whatever form this takes for this setting.

Moreover, we are alerted to the tailoring of the counselling that takes form in this setting, the localised adjustments that groups make for their specific needs (Star, 2010). When a client calls on the telephone and says they want an abortion, the othering of abortion is brought into presence. Not by stating that an abortion trajectory is made absent, but by saying, "really, we would, if they were willing, give them the alternatives" (Interview 4). The contrast in counselling at Lyndhurst and that provided in the pregnancy counselling service exceeded singularity, and for these two services it had become quite different objects. Likened to a boundary object, counselling in the pregnancy counselling service may not be enacted as a professional process according to the aims of social workers at Lyndhurst, but it proved to be

an adaptive device as far as it mediated 'talking work' across different worlds that linked into an abortion assemblage.

Counselling to do with abortion was not contained within the walls of Lyndhurst nor between its rooms. In a similar way to the study of alcoholic liver disease by Law and Singleton (2003; 2005), counselling proved to be a 'slippery' reality that made its way into multiple 'maps' and eluded singularity (Law, 2007)[58]. As Mol and Berg (1998) discuss concerning the idea of medicine as a coherent whole, the unity of counselling, or any other social group providing healthcare, crumble into multiplicities and diversities. Counselling was enacted as a messy, distributed assemblage that was reworked and taken up by different actors across different sites. This reworking and appropriation of counselling by different groups produced tensions concerning the authenticity of counselling and which actors held authority to provide this service. However, as the following section describes, there were many more controversies that proliferated within Lyndhurst.

Othering: Social work on the margins

A collective of actors at Lyndhurst, both human and non-human, enact what is known as abortion provision. Obviously not all actors in this assemblage participate in the same way, or enact the same realities. Doctors, nurses, and social workers are all connected to abortion provision, but are enacted differently. For example, certifying consultants are implicated in arrangements that result in 'certification' of abortion, collective nursing work may produce the 'admission' of service users, medical work in theatre achieves a configuration of 'surgical abortion', and social workers engage in practices that enact 'counselling'.

Within Lyndhurst, the network consolidation of social work was somewhat of an anomaly within abortion provision. Anomalies, as Star (2010) indicates in her account of the origins of boundary objects, present important avenues of inquiry that are often embedded in the action of organisational work. Social workers were employed as part of the permanent crew of staff at Lyndhurst, and were present in this way in the day-to-day action of work. However, social work was found to be 'other' to the core priorities of abortion provision.

In New Zealand, licensed providers of abortion services are required to advise a women of her right to participate in counselling under Section 35 of the Contraception, Sterilisation and

[58] For Law and Singleton (2003; 2005), the study of alcoholic liver disease proved problematic because ALD could not be mapped into a singular disease, nor as an object of care, or a typical trajectory.

Abortion Act 1977 (CS&A Act 1977).[59] This is the case whether or not a woman ultimately has an abortion.[60] This 'soft' form of inclusion mediated by legislation has had effects on how social workers at this site have managed to negotiate their place and worth at Lyndhurst, which ultimately is on the margins of abortion provision.[61] The legislation that contributes to the assemblage of abortion provision indicates there is no requirement for counselling to be integrated as a routine part of abortion provision, other than being a women's right to participate in sufficient and adequate counselling. Thus, if counselling is not mandatory and stabilised into the network of abortion provision, then this in turn has an impact on the place of social work within the abortion assemblage.

A senior social work staff member within women's health noted:

> I36: We don't say "Do you want to have an appointment with a nurse?", "Do you want to have an appointment with the doctor?". But we do say it around counselling and I think that's part of the problem with the way it's set up. It is actually really a bizarre piece of legislation, because on the one hand it says two doctors have to certify that your mental health will be severely compromised if you don't have the termination, yet it says you only have to offer counselling. So it's a really bizarre thing, if you turn it on its ear and look at it, you think, where is the logic in that?
>
> (Interview 36)

As the actor indicates, the formation of one group, such as an assembly of abortion service staff, inevitably involves the assembling of others, "antigroups" (Latour, 2005, p. 32) or non-users (Star, 1991), who have competing ties. In the case of social work, this group fails to

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[59] Arguably, 'mandatory' counselling negates the nature of the counselling process, yet the integration of 'routine' counselling or social work into the process of abortion provision also facilitates an opportunity for women to access information and support. Fiala (2005), while acknowledging that counselling can be a valuable resource, questions the compulsory nature of this practice and enforced delays between counselling and access to an abortion procedure that exist in some localities in Europe. Considering these concerns, counselling is constructed as paternalistic, obligatory and as an impediment to accessing services. Moreover, this challenge is situated alongside the notion that there exist a myriad of medical interventions that do not afford counselling a routine status (Fiala, 2005). While enforced waiting periods between counselling and access to an abortion do not translate to the New Zealand context, the issue of 'obligatory' counselling is relevant despite legislation where the only obligation is that counselling be 'offered'.

[60] Under Section 31 of this Act, it is the role of the Abortion Supervisory Committee to oversee that sufficient and adequate counselling services are available to women.

[61] This mode of 'inclusion' could have been otherwise, as is the case in several other services nationally where social work and counselling staff have a stronger presence. As (Star, 1991) notes, those who reside outside of the standard may well have been assembled differently, but in the arrangements through which social work was enacted at Lyndhurst, social work as 'other' prevailed.

perform the dominant normativity of the setting. Tensions at Lyndhurst about both 'offering' counselling and integrating the service as 'routine' were longstanding where the implementation of counselling at Lyndhurst was located on the periphery of service provision.

Thus, drawing on Law's (2004) attention to arrangements of absence and presence, the place of counselling was necessarily present, but at the same time, it was pressed into absence. Social work and the provision of counselling at Lyndhurst was 'othered'. In an interview for this study, a social worker at Lyndhurst fleshes out how this othering is enacted:

> I52: …I think part of the challenge of working in that role in that service is the lack of acceptance or commitment from quite a good proportion of the staff for having a counselling service on site.
>
> Letitia: And how is that evident to you?
>
> I52: Um, lack of referrals, lack of acceptance of the need for the service, an unwillingness to incorporate or include the counselling service as an integral part of it, the way counselling is offered on the phone at the point of entry, the way a woman has the information put to them that the counselling is available.
>
> Letitia: Can you give me any examples of that?
>
> I52: Its how it's dealt with on the phone when the woman rings about the service, it may be that when I'm within earshot they are offered the counselling, when I'm not within earshot they're not offered the counselling. Or they're offered it in a way that seems very unsavoury. "We have this unsavoury service available for you if you really want it". [laughs] It's kind of like going to a café and asking someone if they'd like a stale bun with their meal. "We have stale buns and you can have one if you want one". You have to be desperately hungry to want the stale bun.
>
> (Interview 52)

Similarly as a social worker, I found on more than one occasion I would overhear the phrase "you don't want counselling, do you?"communicated to service users.[62] In this way, social work was framed as unnecessary - on the margins of the core work of abortion provision.[63] In the

[62] The specific actors who express this have been intentionally unidentified to protect anonymity.
[63] In a peculiar contradiction, in much of the data I obtained from interviews with Lyndhurst staff, the social work and counselling role was described as one that had value as a part of service provision. Perhaps this was to do with which staff chose to be interviewed and those who excluded themselves.

day-to-day grind of work, the inclusion of social workers to the wider team at Lyndhurst, and the services that they provided, was one of debate and discord. I recall on my social work student placement at Lyndhurst, several years prior to my employment, one of the counsellors taping a sign to the sill of the reception window. It read something along the lines of "Counsellors are available to see you now". Placing the sign at the reception window was an effort to bring social work into presence. In the absence of a service that readily included counselling, this material actor assembled with the profession of counselling and taped to the sill in was an effort to disrupt its othering.

Star (2010) takes note in her account of the origins of boundary object of "…those things that do not fit categories or standards which literally or figuratively get shoved into the nearest file folder or functional equivalent…This has come to include people as the objects of both scientific and political marginality or "otherness" (p. 609). I suggest that social work may be thought of in this way - as an assemblage that resides on the cusp of the standardised mode of abortion provision and struggles to fit with the flow of abortion provision that is dominated by medical practices. Referring to the division between social work and medical practices, another of my social work colleagues offhandedly quipped, "They tolerate us, but that's about it".

Therefore, as I have discussed, counselling is contested and 'othered' from the core work of abortion provision that is essentially assembled as a medical service. Social work with its absence of medical practices is assembled on the periphery, outside of the stabilised network. Star (1991) makes an interesting point about this exclusion:

> A stabilised network is only stable for some, and that is for those who are members of the community of practice who form/use/maintain it. And part of the public stability of a standardized network often involves the private suffering of those who are not standard – who must use the standard network, but who are also non-members of the community practice (Star, 1991).

Law (2004) indicates that singularity, or 'out-thereness', is crafted by making some realities manifest and 'real' and conversely producing 'non-realities' or otherness. The practices of counselling at Lyndhurst were enacted outside of the 'singularity' of dominant medical practices. Social workers act in what Star (1991) refers to as a 'high tension zone", at the midpoint of a dichotomy that in the case refers to a straddling of inclusion and exclusion to abortion provision.

One of the ways in which the inclusion and exclusion of social work was negotiated was in relation to the notion of time. Time at Lyndhurst was configured according to the rostering of doctors, and scheduling of doctors' consultations proved a poor fit alongside the practices of social work.

An example from my fieldnotes illustrates this tension of time:

> *"The doctors think the counselling is a waste of time, perhaps you could try framing it in a way that benefitted the doctors" suggests one of the doctors.*

The professional role of social work struggled against a mode of abortion provision that upheld the medical schedules of work. For example, in an hour to an hour and a half appointment, certifying consultants saw approximately four to six service users in the time that social workers might have seen one. In this way, it was impossible for social workers to schedule one appointment to follow the other without causing delays – and disrupting the dominant ordering of the abortion service.

Yet this tension was not solely to do with social work. One of the doctors I spoke with indicated that she wanted to spend more time with patients but was not able to negotiate this – the scheduling at Lyndhurst could not accommodate this. In this way, it is not social work per se that is of issue here, but rather the practices that social worker enact. Different practices, slow practices - unconventionally long appointments compared to the swifter scheduling of medical staff, were difficult to fit into the daily structure of work and seen to inhibit the efficiency of service provision. A social worker from Lyndhurst describes this tension:

> I15: We were under quite a lot of time restraint issues…occasionally we would have doctors knocking on doors saying well if the women doesn't come through now, basically they are not going to see a doctor today so they are not going to get their first cert and they're not going to be booked in, and all that sort of thing…you get sort of clerical things, you'd get phone calls to say "are you nearly finished", so a sense of being rushed sometimes. Sometimes it did feel that it was a negative thing; certainly, because if you're rushing, then you're not really listening as well as you could do, or speed things up.
>
> (Interview 15)

As noted above, a counselling appointment that exceeded an allotted timeframe on the schedule of appointments for the day, or that occurred in an unscheduled manner, disrupted the flow of events. Like Simmonds (1996) describes in her ethnography of abortion, the social workers at Lyndhurst were discouraged from participating in lengthy counselling sessions, by phone calls, by knocks on doors, by the prospect of a client being omitted from the bookings schedule. These activities of disruption on one hand assisted the maintaining of the dominant ordering of abortion provision. However, on the other, the problem of time rendered social work on the margins, 'a waste of time'.

Against a standard of efficiency, social workers as members of Lyndhurst staff are also 'non-members', as Star (1991) indicates, or enacted 'otherness', as Law (2004) might suggest. Social workers failed to be enrolled in this standard, and via the practices of disruption and exclusion, the standard acted back.

Social work Reconfigured

The counselling practices that social workers at Lyndhurst enacted had to be repeatedly performed to maintain the presence of the social work profession. As discussed, this presence was othered in that it was peripheral, fragile and always under threat. The introduction of a new medical abortion service, discussed in Chapter 7, afforded an opportunity to reconfigure the role of social work. Thus, optional 'counselling' at Lyndhurst was reconfigured as a routine psychosocial assessment.

Weike (1996) offers an interesting analysis that shifts from the example of fire fighters to academics, where 'dropping your tools' may be imperative to making ground and avoid being overrun. As Weike (1996) discusses, many factors counter 'dropping your tools' as means to survive, and actors may hold on to their tools at their peril. Relating this to the controversy of counselling, social work actors had mobilised specific texts - abortion legislation, standards of practice, professional affiliations, and qualifications – in order to secure their membership to abortion provision and advance the currency of the existing configuration of counselling. However, in a similar way to Weike's (1996) notion of 'dropping your tools', social work 'dropped their texts' - by ceasing to argue that these actor-networks authenticated the presence of counselling and thus the social work professional identity. Moreover, social work dropped the articulation of its practices as 'counselling', as the predominant task that defines what social workers did.

It was not that these mediators of professional identity – texts and counselling wording - no longer contributed to the social work identity (indeed, they guided the practices of social work

practitioners), but that social work failed to enrol other actor networks, such as reception, medical staff, and service documentation, to include this version of social work practice into service provision. In this way, social work remained vulnerable and on the margins. In an effort to move from the margins and gain inclusion into abortion provision, social work 'dropped its tools', and mobilised a new tool – a routine psychosocial assessment.

In an effort for social work to endure, the controversy of 'counselling' as the mainstay of social work practice was taken off the table. Counselling remained optional and accessible upon request. The uncertainties of establishing a new medical abortion service worked in favour of securing a social work role in a routine psychosocial assessment, and attempted to stabilise a network of 'good care' (Lopez, Callén, Tirado & Domènech, 2010). Thus, alongside the addition of a new medical abortion service, social work appointments changed from being an optional appointment for service users to being an integrated part of the patient journey. This meant that instead of a third of women being seen by a social worker, all women entering the service would be seen. The effects of this new arrangement was that social work had to compromise and adapt to a new way of working.

This new way of working involved shorter appointments - the time that social workers took was always at odds with service efficiency and fitting with the timetabling of the service. Accordingly, what was previously an optional one to one and a half hour counselling appointment became a 40 minute routine psychosocial assessment, with the additional service of counselling being available if this was required or requested. Further, this new configuration enlisted social workers into a schedule where clients were seen back-to-back. This schedule ensured that instead of intermittent work and abundant downtime, the pace of work increased dramatically. In order for all service users to be seen prior to their first doctor's appointment (of 20 minutes duration according to the new schedule), social work staff prioritised their face-to-face client work over their administrative work. Ironically, the more social work presence there was concerning the number of appointments they participated in, the more absent social workers became in a tangible and durable sense within service documentation. One of the social workers at Lyndhurst described the reduction of social work identity in an interaction where a senior colleague articulated social work practice:

> *She said, "They have their tick boxes". That's what she said. Like that is what we do!*

For social workers the scope of their practice was reflected in the way they used documentation as a practice tool and as an account of events. Moreover, the presence of social

workers was woven into the text they produced as part of service documentation. In some cases this further minimised their position.

At Lyndhurst, as the number of counselling appointments increased, the amount of text written into the Care Pathway by social workers decreased. And, the text looked different – there were less paragraphs, less detail, more brief notes, and more bullet points. Evidence of complexities within the counselling session and the detail of this part of service delivery was unseen. In turn, the physical space on the document that social workers had to write was also reduced. This was not done in consultation with social workers, but by managerial and administrative staff within and outside of Lyndhurst. In documentation, the nature of the social work appointment, once afforded the most writing space, became condensed and less distinguishable from the spaces afforded for medical work.

Whilst on one hand, social work gained presence when it was naturalised into the flow of service provision, on the other hand, the constraints of social work practice translated into making the work that was conducted relatively absent in service documentation, which ultimately reconfigured, but maintained its otherness.

Conclusion

I have sought in this chapter to move away from the notion of identity as singular and fixed and have instead followed some of the ways in which professional identity takes from. The notion of 'method assemblage' crafted by Law (2004) has been key to this articulation of the interdependent absences and presences through which professional identity is assembled. Accordingly, the enactment of intertwined absences and presences cultivate more than one mode of professional identity, cultivate different identities for different actors, and the memberships they link in with. Moreover, these multiple alliances and enactments do not tend to cohere but hang together through spaces, materials, and totems that mediate diverse identity representations.

Attention was afforded to the role of non-human actors and their capacity to shape identities, forge boundaries, and membership affiliations. In this way, we have seen how the gate at the border of the grounds, qualifications, and décor cannot be extracted from the assemblage of professional identity without prevailing on how professional identity comes to be. By broadening the conventions of what constitutes identity, the possibilities are opened up for considering how identities are collectively and heterogeneously generated - albeit

momentarily. We are also alerted to the multiplicity of identity and the reworking of identity within varying sets of relations.

This reworking was evident in the concurrent and shifting absences and presences where hidden and unspoken variants of identity can be accounted for. The dynamic nature of identity formation was highlighted by referring to 'counselling' – a set of practices that were contested, mutable and multiple within and outside of social work networks. In a similar way to the formation and reformation of professional identity and the variants that emerge, the notion of multiplicity takes primacy in the next chapter as this thesis moves forward to talk about versions of 'the body'.

Chapter Five: Versions of the body

Introduction

Earlier chapters have attended to the notion of multiplicity in different ways. In Chapter 3, the multiple ways that abortion is *articulated*, were described. Chapter 4 navigated accounts of multiple memberships that featured as part of professional identity. In this chapter, I turn my focus to the body, and experiment with Mol's (2002) notion of multiplicity in relation to the body in abortion assemblages. In her book, 'The Body Multiple', Mol (2002) argued that there is no such thing as 'the body' as a whole. Mol's (2002) topic is a disease of the body, atherosclerosis, that through attention to different sites and practices is seen to take various forms. For example, the pain that a patient may experience on walking is a different enactment of the atherosclerosis in the operating theatre with the attention to unblocking arteries, which is different again in the pathology lab where the body that has been sliced and sorted is put under a microscope. As Mol (2002) describes, by following the various practices at different sites it becomes evident that there is not one atherosclerosis that takes form, there are multiple versions that are enacted and thus produce a body multiple.

Further, Mol (2002) asserts that whilst it is possible to 'know' the body by treating it as a singular 'object' on which different perspectives may be generated, it is also possible to consider the body differently – as it is *enacted in practices*.[64] Before I move into discussing multiplicity, and ideas about how the body is enacted in practices, I need to traverse the notion of perspectives.

It is possible to argue that conventional research on or about the body is driven by perspectives. Perspectives are generated by treating the body as a singular object. Thus, perspectives that are developed from theories and frameworks, are held by the researcher, imposed on the actors involved, and later revealed to the reader. In this way, perspectives on the body hold the body at a distance. As Mol (2002) has argued, a focus on perspectives "multiplies the observers – but leaves the object observed alone. All alone. Untouched. It is only looked at" (p. 12). Moreover, these perspectives, to do with 'knowing' the body, tend to

[64] For Mol (2002), 'objects', such as the body are enacted rather than performed as Goffman (1959) articulates.

dichotomise the body into medical, objective realities, and social, subjective realities - a dichotomy that, like Cussins (1998), I argue against in this chapter.

The fleshy, physical substance of skin and all it contains within it may be considered as the object of medical knowledge and often considered an objective reality (Mol and Law, 2004). Mol and Law (2004) have referred to this as 'the body we have'. The health professionals who use frameworks and knowledge sets to assess, examine, diagnose and treat the body are crucial actors in the assemblage of health care for women in New Zealand. At Lyndhurst this is no different.

When abortion is characterised within health as "simply another medical problem" that "you treat", it links in with what may be deemed a *medical model*. This lens locates abortion within the skin as a fleshy, physical bodily reality.[65] 'The body' in this context is situated as the object of medical knowledge and it is the problems with this body-object that drives medical treatment. The *medicalisation of the body* concerns the conversion of the conditions of the body into the problems of medicine and of medical definition, where the body, rendered passive, may be treated as an object of scientific knowledge. Medicine may well shape bodily realities, but questions about which versions of medicine and in what ways this happens requires attention.

As a number of authors discuss (for example, Hirschauer, 1998; Mol and Berg, 1998; Pols, 2005; Rose, 2007), medicine is not a singular and unified entity. The body can be read as medicalised, but this does not necessarily allow for the multiple and fluid ways in which medicine takes form. Rose (2007) articulates this as follows: "Medicine has no essence, be it epistemological (there is no single medical model), political (the power of medicine cannot be reduced to social control or the management of social problems), or patriarchal (medicine and medics do not merely seek control over women and their bodies)" (p. 700). Essentially, I, like other ANT authors, am arguing that medicine is rich and diverse in its practices.

Rose (2007) cautions against both the pre-packaging of the 'we' who enter medical sites and make use of medical expertise, and of the medicine and expertise that 'we' refer to. Instead, it is necessary to consider specifically the heterogeneous actors and practices that articulate the body. Moreover, like Mol and Law (2004) have argued, the body as a 'singular' object or as a

[65] Mol and Law (2004) discuss the body that we have (a body-object reality) and the body that we are (body-subject reality) to denote object/subject dualism as they shift to discussing the body that we *do* as the body enacted in practices in their account of enacting hypoglycaemia.

'whole', masks a great deal of activities and tensions and work. Being and staying 'whole' is an effortful and ongoing process that takes place in practice.

It may be problematic, then, to think of the 'body-object' as a discrete and tidy bodily reality. It is here that I begin to refer to the notion of 'the body we are' (Mol and Law, 2004). In contrast to the body-object that we have, the body we are is a self-aware body based on lived experiences (Mol and Law, 2004). So, 'the body we are' is more to do with what is subjective and it recognises the self and the notion of identity. Within abortion provision, medical staff could be seen to work predominantly with versions of the body-object and act on the body of the patient with their medical expertise. At the same time social workers, informed by an alternative set of guidelines, frameworks, and theories, were more aligned to work with the body-subject and the meaning that abortion had for their clients.

The words, 'client' and 'patient', illustrate this delineation of practice focus within the service – but each perspective is informed by guidelines, regulations, and practices embodied in texts. However, in reality, this delineation of work with bodies as well as the composition of the body itself is less contained (Mol, 2002). The body is not neatly divided, and does not map neatly into either body-object or body-subject realities. 'The body' is slippery - both physically and metaphorically.

Drawing on the work of Mol (2002), Mol and Law (2004), and Latour (2004), I am arguing that, just as medicine cannot be reduced into a singular entity, nor can the body. This opens up possibilities through which both the body and abortion may be understood. By following how the body takes form through abortion sites and practices, the focus shifts from top-down perspectives to local bottom-up abortion realities. This is because, as Latour (1999) says, it is not the actors who are deficient in knowledge, it is me as the researcher who must learn from their world:

> It is us, the social scientists, who lack knowledge of what they do, and not they who are missing the explanation of why they are unwittingly manipulated by forces exterior to themselves and known to the social scientist's powerful gaze and methods. (p. 121)

The ANT sensibilities that inform this thesis mean that, rather than explaining the versions of the body in abortion assemblages, I am describing them. The descriptions of various versions of the body will allow us to learn from the actors involved. It is this closeness to the bodily realities that allows me to look at how the body is enacted. While I consciously focus on

staying close, I am not seeking to interpret the body. Rather, I describe 'the body we do' (Mol and Law, 2004) and how the body is *done* at Lyndhurst. This means that I describe how the body is enacted at Lyndhurst and at peripheral sites, such as those in general practitioner surgeries and laboratories. It is not for me as the researcher to explain these enactments to the reader, but to provide descriptions of specific practices that allow versions of the body to be revealed.

I begin to describe specific rather than global ways that the body takes form. My focus on specific practices reveals a body less certain, more dynamic, more affected or, as Latour (2004) suggests, 'effectuated' by the human and non-human actors it is enacted by (p. 205). Consistent with the thinking of Latour (2004), we can see that a woman's body may be known as "an interface that becomes more and more describable as it learns to be affected by more and more elements" (p. 206). In this way, the body I describe is assembled through its sensitivity to the actors it combines with and in the practices through which it takes form.

Building on and also moving away from Foucault and his attention to order or orders, Mol (2002) considers 'modes of ordering' or ways in which, rather than a single network, there may be multiple networks – coexisting networks - that may be coordinated in divergent ways. Latour (2013) more recently has expresses this as 'modes of existence'. I have elected to follow Mol's (2002) version of multiplicity because of its links with health, care, and associated practices. I have presented a snapshot of sets of practices that invoke the body to show some of the ways in which 'the body' that is connected to abortion and indeed, abortion itself, may be assembled. Like Mol (2002) I do not seek to draw conclusions or generalise about the practices I present. Any resolution about the body is left undone and open to further configurations. Indeed, Mol (2002) has stated that this is a "permanent possibility" (p. 164).

In the first section I introduce the notion of multiplicity by attending to the instability of the pregnant-body that is part of abortion assemblages. Here this version of the body is 'held together' by the way it evades order and control – its unruliness. This is a body that has entered the networks of abortion because of its inability to be 'tamed' (Mol, 2008). The pregnant-body begins to take form through the 'hormonal messengers' (Roberts, 2007) that disrupt the non-pregnant-body and become 'visible' in pregnancy signs and symptoms. Attempts to try and tame the pregnant-body involve the addition of contraceptive devices that are characterised by their own unruliness in that they may 'act back' against the actors – doctors and service users – who rely on this actor's compliance. This section concludes with a further effort to order the pregnant-body – that of treatment.

Secondly, the pregnant-body is reconfigured where a further version of the body takes form in texts - a textual-body. Like Mol (2002), I insist that the body is enacted beyond its fleshy form. Non-human actors such as texts are vital to generating a version of the body that has currency: Currency to gain entry, mediate engagement, to articulate bodily truths, and to sort and circulate the body through abortion assemblages. To attend to 'the body' and provide care as part of abortion provision is also to be responsive to the texts through which textual-body emerges.

Finally, I argue that in the space of the operating theatre, the body is enacted through different arrangements of agency to produce a patient-body. Various actors, such as theatre staff, medications, the operating table, and the voice, produce dynamic practice arrangements through which the body becomes both subject and object. Here, the body-object and body-subject are neither discrete nor predetermined. Instead, the patient-body emerges in and through a 'choreography' of agencies.

From this account of bodily versions it will be clear that there is no singular body that enters and travels through abortion networks. The body cannot be reduced in this way. Attention to practices reveals that divergent bodily enactments are generated in specific heterogeneous relations, there are multiple bodies, and thus, multiple abortion realities.

The Pregnant-body

In this section I attend to some of the uncertainties and disruptions of the body. As has been articulated through the concept of multiplicity, the body may be assembled in multiple ways. It is not fixed but emerges through various practices. The pregnant-body is a body that emerges as a body that is difficult to order and control. The body has changed unexpectedly to a pregnant form, its unruliness mediated through the inclusion of contraceptive devices that, in turn, cannot be relied upon. A pregnant-body within abortion networks is a body that is treated. This treatment intervenes on the body and brings order by disrupting the acquired pregnant bodily state. Initially, however, it is 'hormonal messengers' that are the means through which a pregnant-body can be registered.

The Hormonal Body: Signs and Symptoms

Prior to the engagement of reproductive technologies, such as the home pregnancy test and the scanning practices that are discussed in Chapter 6, 'hormonal messengers' (Rose, 2007) can articulate a 'pregnant-body'. As Rose (2007) suggests, the notion of 'hormonal messaging'

has potential to weave 'the social' and 'the biological' together where the 'clean' and unachievable space between these can be bridged.

Mol and Law (2004) in their study of hypoglycaemia suggested that as part of enacting the body as a whole, 'patients' 'read' the body from the inside-out – they 'felt' changes that are located within their body. In the case that Mol and Law (2004) articulated, an actor may identify the presence of hypoglycaemia through the messages of blood sugar - the concentration of glucose in the blood - where appreciating the change in the body to 'being low' relates to a drop in blood sugar levels. Similarly, the hormonal messengers within the body 'translate' or shift the form of the body where prospective service users of Lyndhurst can be alerted to a change in the 'usual' state of their bodies to this being enacted as a pregnant-body. The accounts from service users below offer an indication of how the hormonal messages are registered through the signs and symptoms of pregnancy:

> I7: I don't think my period had been very far gone but I had all these kind of signs, you know, I had really sore breasts and I had really bad cramps in my tummy and stuff.
>
> (Interview 7)

> I45: My period didn't come. And one night I woke up in the middle of the night and felt sick – I wanted to throw up. There were many signs; like my emotions were a bit down.
>
> (Interview 45)

This inward reading of the body contrasts with the registering of signs and symptoms that tend to occur later, by accessing the body from the outside with devices such as pregnancy tests and ultrasound scans and the manual examinations that may take place within doctors' surgeries. Before these interventions on the body occur, it is the hormonal messengers that enact a pregnant-body.

These hormonal messengers may mediate a range and varying degrees of signs and symptoms that include, but are not limited to, amenorrhea, breast swelling and tenderness, nausea, emotionality, and fatigue. In this case, it is from the inside, through the messengers of bodily change, that a pregnant-body is *acquired*. Latour (2004) describes a situation where becoming a 'nose' in the perfumery industry is acquired through registering new elements and becoming sensitive to contrasts; similarly, in the assemblage of abortion the possibly-pregnant woman

discerns pregnancy through the hormonal messengers that mediate new bodily changes, and she becomes sensitive to these pregnancy signs.

However, this acquiring of a pregnant-body is not limited to the appreciation of hormonal messengers alone. A further component of the pregnant-body concerns a body that has betrayed its ordinary state and has become unruly.

The Unruly Body

The bodies that enter the sites of various medical services need not be ill. As Rose (2007) has indicated, the field of medicine concerns not merely illness but health and the management of life itself. Accordingly, while abortion *is* to do with healthcare practices, specifically as this concerns women's health and reproductive health, it is not typically to do with disease or illness.[66]

One way of recognising the relationship abortion has with healthcare is by considering the notion of bodily disruption that precedes and mediates the engagement of prospective service users with abortion provision. For prospective service users, as prefaced by the attention to the hormonal body above, the body has undergone a shift from its ordinarily un-pregnant status to becoming a pregnant-body. As tends to be the case within abortion networks, this change in bodily state is as much a disruption as it is a transformation. As Mol, Moser and Pols (2010) suggest, bodies that have not complied with the specific desires and expectations of those who occupy them have become "unruly" (p. 10).[67]

As Mol (2008) suggests, a 'well-tamed body' is characterised by its absence. So, a body that has been tamed would not re-enter the spaces of abortion provision. Yet, untamed bodies do. Of the 13,137 abortions that were performed in 2014 in New Zealand, 3,128 service users had had a previous abortion, and an additional 1,694 service users had had two or more previous abortions (ASC, 2015). Brown and Webster (2004) premise that understanding human life

[66] Abortion sits precariously under the medical umbrella of health care due to its legal entanglements and controversies. Capturing some of these entanglements and controversies, Hill (2009; 2010), from a US legal lens, argues that abortion should be described within the context of health care and argued for as a right to health. More specifically, Hill (2009) argues that this should take the form of a "negative right" to health care where women should be free from governmental interference concerning their right to access health care and their autonomy concerning medical decision-making (p. 503).

[67] While in New Zealand and other localities it is not unusual that a pregnancy occurs unexpectedly, and in many cases does not follow an abortion trajectory, when we seek to know the body that is part of an abortion assemblage, then its unruliness cannot be unhooked from abortion practices. For example, see Singh, Sedgh, & Hussain, (2010) whose research indicates that approximately 40 percent of pregnancies globally are unintended, and for New Zealand data in those under the age of 25 see Dickson, Wilson, Herbison, & Paul, (2002).

through an orderly life course trajectory is problematic as the realities of human existence, as indicated in health, justice, and governmental systems, rests on the inability of life to be orderly and predictable. The prospect of an unplanned pregnancy is an example of the 'disorder' of life articulated by Brown and Webster (2004) above. It is the relatively common occurrence of unplanned pregnancy that may prove problematic for those who occupy these pregnant bodies.

A social worker connected to abortion provision speaks to this below:

> I36: The notion of pregnancy is that there's this group who have failed to manage their fertility and they've ended up pregnant. If you looked at the whole population, many pregnancies would be unplanned…it's actually a reasonable thing to think that within your fertile years you will have an unplanned pregnancy.
>
> (Interview 36)

The normalisation of bodily unruliness as this relates to unexpected pregnancy is implicit in the quote above. However, it is not always the case that the unruly bodies that enter abortion provision must be tamed and held accountable solely by those who inhabit them. Health professionals, such as the staff at Lyndhurst, are also invested in the attempted management of the unruly body.

At Lyndhurst, doctors readily prescribe contractive devices as a means to order the body. However, a prescription on its own is not enough to maximise the prospect that the contraceptives will work. A further addition to the unruly body is the 'contraceptive talk'. Added to the doctors input, instructions for contraceptive use, for various pills or insertion of devices such as IUDs and contraceptive implants, were provided by nursing staff on the day of an abortion procedure. Yet, unruly bodies may be no more compliant for health professionals within abortion provision.

When a past service user re-presents at Lyndhurst for a further abortion, the nurses at Lyndhurst may wryly ask in the arrangements of handover in the tearoom, "ok, who did the contraceptive talk last time?" This insertion of humour affords a means to navigate workplace challenges in which the unruly body is implicated.[68] This presence of unruliness then, not only

[68] Joffe (1978) offers a different view where counsellors in an abortion clinic articulated anger and the repeat entry to abortion provision of clients. I found that the use of humour inverted the frustrations of staff when service users representing at Lyndhurst. A different version again is offered by Poppema and Henderson (1996) who indicates that re-entry into abortion provision is difficult for service users and that the 'comfort' of good care should not be underestimated.

points to the challenge that women may encounter in the management of their bodies, but also to the challenges of uncompliant contraceptive actors and the continuing efforts of health professionals in attempting to manage this unruliness.

Of further interest in the quote above is that the attention given to the human actors that have 'become' pregnant. However, it is not simply the actions of these human actors that is at play here. It is important to draw attention to the non-human actors, the materials that are invisible in such accounts. Contraceptive devices are key actors that are enrolled in abortion networks, amongst other networks, in the attempt to bring order to the body. However, given the inability of life to be orderly and predictable, it is not surprising these actors might act back.

Contraceptive devices, pills, condoms, other apparatus, and various techniques, are part of the body assemblage within abortion networks. They may be enrolled in body practices to tame the body and disrupt the prospect of pregnancy; however, these devices may be unreliable when present and, of course, pregnancy can occur in their absence. In this way this ensemble of actors are no more 'well-tamed' than the pregnant bodies that enter Lyndhurst. So, it is possible to consider the unruliness of contraceptive devices alongside the unruliness of the body.

A doctor at Lyndhurst illustrates the tensions of working with contraceptive devices below:

> I23: …she was really angry. When I asked her about contraception, "had she been using contraception", she got more angry and said, "of course I wasn't, why do you say that, is it just to rub it in, of course nobody's used contraception when they come here". And I had to say, "well, actually a lot of people have used contraception when they come here and the reason we ask isn't to humiliate you, it's because you might have been on the pill, you might have taken it wrong, so we need to establish that, you might have taken it right and we need to establish why it failed and find something that's more suitable for you".
>
> (Interview 23)

Nothing is stable. Contraceptive devices, the material actors that are enrolled to bring order to the body, act back and disrupt attempts to tame the body. In the quote above, the doctor is seeking to ascertain the *cause* of the body's unruliness, and locates this as mediated by the absence, the use, misuse, or failure of contraception.

Part of the assemblage of the pregnant-body within an abortion assemblage is the inclusion of contraceptive devices that act back. It is not enough to 'use' a contraceptive, like the pill indicated above. The pill, for example, must be assembled with the body in a certain way. If it is taken incorrectly, it can fail. In this way, pills can be a fragile and unruly means of attaining bodily order. The unruly body may also include correct contraceptive use as part of this assemblage. However, even if the pill is taken correctly, it may still fail or act back against the actors that rely upon its alliances.

Through the inclusion of unruly contraceptives in assembling the pregnant-body, we are alerted to the way that these non-human actors mediate an 'unexpected' form of power (Law and Singleton, 2013). In this way, the presence of power in any given arrangement of actors and practices is not something that can be assumed without looking first to the actors and what they say and do. After this, asymmetries may then be revealed. This is particularly apparent when problems occur (Law and Singleton, 2013). Contrary to the notion that power is something that is held by a particular actor, Law and Singleton (2013) argue that "We need to start from the assumption that both kinds of power, "power to" and "power over" are being endlessly done in the webs of practice" (p.494). As any mode of power is generated momentarily, various disruptions prove interesting for what they reveal about power arrangements.

While contraceptive devices may assist in managing bodily unruliness, they cannot be relied upon to be taken up according to their rules or action. Moreover, contraceptives may not work as expected and may 'act back' against those who are invested in their role, both the service user and the doctors who prescribe their use. A further set of practices are involved in the enactment of the pregnant-body – that of treatment.

Treating the pregnant-body

It is because of this lack of fit between the occurrence of pregnancy, and a bodily state that is expected and desired, that intervention in the form of abortion provision occurs at all. It is, after all, pregnant women with unruly bodies who come to be service users at Lyndhurst. Abortion is not a matter to be 'cured' in the manner that some health care concerns and provisions afford. But the pregnant-body that enters abortion provision can be, to employ the wording of medical practices, 'treated'. The treatment of abortion mediates a further disruption where the state of the pregnant-body is shifted from its 'natural' trajectory. In this way, both the unexpected adding and planned taking away of pregnancy is an intervention that is other to what might be deemed the 'orderly' course of life events.

> I19: … the reality is that like anything, abortion is simply just another medical problem…you go to a doctor with a urinary tract infection, you want it treated, if you go to a doctor with an unwanted pregnancy, you get it treated. In a way it's not a huge amount different, to me. You know, the sad fact of life is, well, it's like infertility, infertility's a medical problem, well, you treat it, and so is abortion at the end of the day. It's an unwanted growth, if you really want to pare it down to its very basics.
>
> (Interview 19)

The excerpt above allows us to draw attention to what abortion shares with other health concerns. Rather than illness or disease, the body is more in a state of dis-ease,[69] where it has become misaligned with what is desired of it. According to the actor above, medical practices at Lyndhurst do not necessarily differentiate between the unruly body of disease and illness and the unruly dis-eased body that enters abortion provision. Thus, attending to this 'unruliness' at Lyndhurst is not unlike the approach of other medical care practices in other care settings. Abortion is, as the informant above describes, "just another medical problem". As a medical problem, abortion is located within the body – "an unwanted growth, if you really want to pare it down to its very basics". By paring it down to its very basics, the doctor discards the many other configurations of abortion that are available in order to foreground the problematic body that she is employed to resolve.[70]

It is not only one version of the body that gains relevance within abortion provision. The body is neither fixed nor one thing. In a similar vein to Mol (2002), the body is enacted in different practice arrangements. These need not always align. Indeed, as Law (2006) concurs, nothing is enacted as whole, even momentarily. Instead, the body must be made and remade, generating ceaseless links and clashes as an "ontological patchwork" (Law, 2006, p. 67). Adding to this patchwork that comprises versions of the bodies of abortion provision, the following section attends to the significant contributions of texts to assembling a further version of the body.

[69] I use Daniel David Palmers' term 'dis-ease' here, a term developed from his founding of chiropractic practices, to convey that the body that enters abortion provision is not diseased or sick but in a state that is *misaligned* with what the service user may perceive as optimal. Palmer coined this term in the late 1800's to refer to the misalignment of the bones as the cause of 'dis-ease'.
[70] There is a similarity here to Hirschauer (1998) and his reference to the 'wrong body' given sexual preference and the development of genital surgery

The Textual-body

In this section, another version of the body within Lyndhurst is presented. For abortion provision to be enacted, the body must gain access to Lyndhurst and circulate through the service. To do so, this pregnant-body, must be reconfigured. In order for staff to work with the bodily unruliness indicated above, the body must initially take form in texts. In texts, the body is enacted quite differently. Texts involve a different set of relations, materials and practices. The body becomes something that is assembled, that moves through spaces, that is interacted with when the body is absent, and that speaks the 'truth' about the body.

The texts that constitute the body at Lyndhurst have emerged as a consequence of complex sets of practices at other places. Similar to Mol (2002), the body is separated and distributed across different sites. As this concerns Lyndhurst, GP surgeries, medical laboratories, and radiology settings are implicated. Accordingly, from the sites mentioned, referral letters, blood test results, and ultrasound scan reports have been produced.

In this preceding work, the body has been transformed via various systems or 'inscription devices'. As demonstrated in the work of Latour and Woolgar (1986), inscription devices are sets of arrangements that convert relations into a traceable form such as figures or diagrams that, in turn, are rendered usable by subsequent actors. For example, when doctors at Lyndhurst require the blood test results of the service user, it is not necessary to transport the blood, the technicians and all the equipment, instruments and processes of the laboratory to Lyndhurst to access this information and work with this part of the body. All of this work is reduced, fixed and circulated in text and made accessible to this audience without the need for their direct involvement in the preceding events (Latour, 1987). Text allows sets of practices that do not travel well in their original form from one site to another to become transportable and stable (Latour, 1987).

In the textual outcome of this work, the traces and the production of the text fade away (Latour and Woolgar, 1986). In this way, inscribed realities are orderly and they are also selective. Thus, while inscriptions attest to multiple sets of connected working practices, the details of these practices largely remain hidden (Law, 2004). Hence, the blood test result mentioned above does not show the complexities of the work that precedes this text and how the result came to be. It is through text, then, that sets of practices may become 'punctualised' or black boxed where the test result is a singular representative for the complex set of events that it denotes, and ultimately obscures, as part of the representation. It is the text itself that is

afforded primacy by those who engage with it. Moreover, it is through texts that a version of the body is assembled.

In this section on 'Textual Bodies', there is the residue of Latour's (1999) concept of 'circulating reference', and his analysis of a field expedition in the Amazon forest that will be discussed further in Chapter 6. In order for the forest to 'circulate' by being made into a report, the forest needed to be sampled. Specimens of the forest "'made reference'" to the forest as a whole, both by acting as a representative of the species of plants they refer to, and a guarantor that can be revisited in the case of any disputes (Latour, 1999, p. 34). In a similar way, the texts sample the body, its blood, fluids, and pregnancy measurements, to make reference to the body as a whole, and via this translation into text, enables the body to move, not only in text but by opening the gate for the body in its fleshy form. Yet, even when the body in flesh enters the service, it is held at a distance. Engagement with the body, via text, is key.

Assembling Texts: Assembling the Body

Initially, it is in the back office at Lyndhurst where the reception and administration staff come to know the service user in textual form. The activities at the different localities outside of Lyndhurst culminate in interrelated texts.[71] From this ensemble, the body of the patient is (re)presented in words and figures, beyond the boundaries of its fleshy reality.[72] This influx of text does not pass through Lyndhurst in the same form, but is translated into practices with the body and the body itself, as a receptionist at Lyndhurst notes below:

> I44…I mean there's usually about 30 faxes here when I get in on a Monday morning. All these people, I'd love to know what they all looked like…
>
> (Interview 44)

Through a multitude of faxed data, the receptionist gains a version of who the 'people' are that will pass through the doors of Lyndhurst. She does not know what they look like in a

[71] See Atkinson and Coffey (2004) concerning 'intertextuality'.
[72] Law and Singleton (2003) note in their study of alcoholic liver disease that health concerns are "located both within and beyond the body" (Law, 2004, p. 76). Similarly, but on a different topic, Abrahamsson and Simpson (2011) offer an account how of the body can take form beyond the limits and boundaries of its physical substance in their analysis of rock climbing. On the same object, Barratt (2011) articulates the hybrid 'climbing assembly' that affords the climbers body access to 'vertical worlds'. There is a similar argument in this account of abortion where the body is textually assembled beyond that flesh, and whereby this assembly mediates access to abortion provision.

conventional sense where this refers to a body that might stand in front of her desk. She is, however, afforded a version of these actors in the faxes that she handles.

When a service user is referred to Lyndhurst, an array of incoming documents, a referral form, blood test, and swab results, and an ultrasound reading that arrive by fax, courier or email, are assembled by administration/reception staff. The referral form from a general practitioner identifies the age, culture, and reproductive history of the woman, including past pregnancies and births, miscarriages and terminations, and the reasons as to why the woman might have requested a termination of pregnancy.[73] Information about blood, fluid and particular cells of the body that had been ordered by a general practitioner and processed by laboratories were obtained and assembled. An ultrasound scan report in text that measured the gestation of a women's pregnancy was gained from radiology centres. The incoming documents and the office staff work together and in these human/non-human interactions, a body in and of text emerges wrapped in a cardboard casing, a patient file, as part of the *The Lyndhurst Hospital Multidisciplinary Care Pathway (*the "*Care Pathway*" hereafter*).* Rather than refer to a "patient file" (or medical record or chart), I talk about the *Care Pathway* as a more localised identifier of this package of service documentation.

The *Care Pathway* holds these multiple bodily realities together. Similarly, Mol (2002) has described that when the body as a singular entity is broken apart to reveal multiple body enactments, these remain connected and 'hang together' somehow. The *Care Pathway* in this chapter is seen to facilitate this connectivity or hanging together. Further, as Berg and Bowker (1997) have noted, the human body of the service user has been deconstructed, geographically distributed, sorted, measured, classified and reassembled in text. As specific elements of the service user are privileged for a time, the service user is made textual, tangible, and mobile as various texts afford a version of the walking, talking, thinking, feeling body that has not yet arrived.

Whilst one way of knowing about the body is as a composite of scientific measurements, parameters and visual representations (Duden, 2000), the service user is not reduced to only that bodily representation – but that representation is part of the body as a whole. As Mol (2002) explains, the body as a single entity is also multiple and in this set of arrangements it is represented and held together through documentation. Indeed, it is through incoming documentation – the faxes, emails, couriered results – and the work of the back office and

[73] As the Abortion Supervisory Committee (2012) report indicates, a standardised referral system has since been introduced for abortion providers.

arranging of texts, that the physical body *can* arrive. A preceding version of herself. And, this documentation is assembled piece by piece. From this work with texts, the gathering and assembling, the body too is gathered and assembled bit by bit.

The arrival of the pregnant-body and its consequent mobility depends upon the 'obligatory passage point' of culminated texts that act as a collective spokesperson for the body (Callon, 1986). Obligatory passage points are nodes in the network where actors have a shared interest on a certain topic and delegate focal actors to uphold this interest (Callon, 1986). Accordingly, a focal actor, in this case, the assemblage of texts that produce a body in the Care Pathway, satisfies the interests of a range of actors and becomes a point through which other actors must pass – there is no negotiation concerning this.

Texts are the means through which the pregnant-body of the service user must 'flow' through to assume a stabilised and factual status. The assembling of the body via the collection of preparatory, interrelated documentation served as an indispensable means of entry to the service for the service user to obtain and access care. There is no open passage that permits the pregnant-body to walk through the doors of Lyndhurst on her own and unannounced. Nor for staff at Lyndhurst to usher the pregnant-body through on their own terms. Access to abortion provision cannot be negotiated by the pregnant-body alone. These actors are compelled to assemble with a consort of actors that includes the textual-body that has already arrived and has been substantiated by the receptionist in this form.

A single document cannot pass through the site of the reception office on its own. These documents must come together to map and reference the body. Staff rely on this to do their work. Similar to Latour (1999) and his reference to the use by scientists of multiple maps to locate the site of study in the Amazon forest, health professionals may aim to "master the world", or in this case, tame the pregnant-body - but only if the body comes to them in "two-dimensional form" (29). In this way, documentation becomes a spokesperson for a collective of actors (Callon, 1986). It is possible to acknowledge the agential properties of non-human actors by considering that Lyndhurst staff, the service user, and referring agencies, must comply with the requirements of documentation that 'speaks' on behalf of abortion provision requirements. The incoming documents are privileged, their paper a mediator of insight into the truth about the body, and consequently, this version of the service user.

> I43: We don't respond to any of the faxes that come through either. I file them, well depending on the amount of weeks…But as I say if it's 11 or even 10 and a half weeks, I'll ring the GP… I check all the faxes and I put a post-it on them… I have to make up all

> the operating lists… I make up the chart [patient file] off my booking list… There has to be the referral letter, the social work report if they're from out of town, a referral letter, the scan report, the first antenatal blood screen, the Chlamydia results and all of the swab results. And I'd say 80% of the time they're not there. So therefore I have to physically ring a lab, either of the labs, the scan places…That's what has to be in all of the charts and if it's not there and I haven't got time to get it or it hasn't been done then I have to ring back to the GP and request that it be done… It's all detective work...you don't have the information, it's missing, you have to track it down
>
> (Interview 43)

The documents act as a proxy for the service user and her access to the services at Lyndhurst. However, as the actor above laments, the documentation as a package may take some detective work to get together. Often, reception and administration staff at Lyndhurst actively track and assemble documentation that has been omitted as part of the referral process. Documents make the enactment of abortion provision possible or block this access if part of this paperwork is missing. Through the detective work of tracking texts down, and the gathering of texts together into a file, texts afford the service user an official means to enter service provision. Once the textual-body has been initially assembled, and the service user has entered the service in her fleshy form, the patient file can begin to circulate and the service user can also move within this setting. Staff will also move, back and forth through swinging doors, treading their patterns of movement throughout the building and back and forth between the file and the service user they care for.

Engagement at a Distance

For staff at Lyndhurst, documentation was a medium through which receptionists, social workers, doctors, nurses and nurse aids engaged with and carried out their specific roles and tasks. Through documentation, these staff did not need to be physically present for the complex activities that preceded and followed what was pertinent to their role. Instead, staff relied on the representations of these activities to inform and mediate their role and the tasks they are charged to undertake. While one of the outcomes of the collective work at Lyndhurst concerns the provision of care, a further outcome of this work is the production of a document, the *Care Pathway*.

The sequence of the *Care Pathway* identifies certain tasks that, once undertaken, produced further inscriptions that produce further tasks, and so on (Berg and Bowker, 1997). It is through these cycles of activity and representation that demonstrates what Pols (2012) has referred to within the realm of healthcare practices as 'care at a distance'. For Pols (2012) this occurs under the umbrella of telecare, where various communication tools such as webcams, electronic monitors, and email are 'distant-care' devices that support the health and wellbeing of chronically ill people living at home (Pols, 2012). At Lyndhurst, staff need not venture far in order to enact a form of these 'distant-care' practices with the patient-bodies that enter abortion provision.

At Lyndhurst, the texts of the *Care Pathway* offered the intimacy of a 'body' to work with even in its immediate absence. Moreover, these texts compel staff to 'care' and act on behalf of the patient-body. For example, in the *Care Pathway* a version of the patient-body is present in the tearoom during staff handover when the physical body is immediately absent but close by within Lyndhurst, in spaces such as the waiting room or a hospital bed. In the tearoom, staff gather, drinking tea and coffee, and eating toast. Preceding work stops momentarily in order for nursing staff to familiarise themselves with the patient-bodies that have presented for the day. I notd in my field notes:

> *…The patient files were stacked on the coffee table and [nurse] picked the first one up, "[name] is a 22 year old primip [primipara – indicating a first pregnancy]. She is here today with her partner and two other support people…she has taken the pills, no problem…*

Handover entails a reconstitution of the textual-body combined with preceding activities of care. The texts of the patient file assemble a version of the body that the admitting nurse has also encountered in its fleshy form. The nurse then distributes these multiple versions of the body via articulation to their wider team. The age of the service user and the indication of a first pregnancy are assembled in texts. This is overlaid with the additions of accompanying support persons and the combined role of the admitting nurse that administers pills, and the action of the service user in taking these pills without problems. These different versions of the body enable staff to do their work. As Berg and Bowker (1997) discuss, not only does the 'medical record' compose a textual patient history and a geographical map of split and juxtaposed bodily realities, but "The medical record is a distributing and collecting device (Berg, 1996); work tasks begin and end there" (p.519).

This engagement at a distance reconfigured the understanding of engagement I held as a social worker at Lyndhurst. My first encounter with a 'client-body' was not when I met them in the waiting room prior to the counselling session, nor was it when I heard their voice or when we entered into a discussion. Like many settings, in health and otherwise, a version of the client has already been produced in documentation. Through the practices of reading, like Berg (1996) has discussed, my engagement with documents not only mediates what professional activities should come next but plays a part in shaping this situation – in this case, in shaping my engagement with the client-body. Thus, when I engaged with the client initially and began to form a connection of sorts, it was not through face-to-face *talk* with the service user. It was instead through an engagement with *text,* the referral form, and scan result, where I would read these words and figures. In textual form, I 'met' and inevitably started to build an understanding of the client-body. The *Care Pathway* composed a textual-body to work with this clients' immediate absence.

Sorting bodies

The organisation of the patient file mediates the organisation and production of bodies – human bodies, the bodies of staff, and the body of the organisation (Berg and Bowker, 1997). Alongside the textual emergence of the service users, texts acted to mobilise workplace tasks and deployed sets of practices that enrolled other bodies. In the immediate absence of a fleshy body to work with, it was a textual-body that was present in the action of early practitioner-client relations. Because of text, 'we', social work staff, sorted the bodies of not only our clients but our own. We arranged our bodies through the texts that composed the service user in order to try and determine a best fit between worker and client.

While it is hardly revolutionary that service users are allocated via referrals and textual information, it is also useful to unpack and reflect upon our relationship with workplace documents. At times, the documents we engage with have little to do with the agency of service users and more to do with organisational processes and professional decision making. Like Stanley, Du Plessis and Austrin (2011) indicate, decisions and responses, even those that are preliminary, are made upon these 'facts', even when the client is left out of decision making.

In my social work role, because of texts, I knew the age of a presenting client. Thus, my social work colleague and I sometimes allocated this textual-body to a particular social work practitioner. At Lyndhurst, and well into my 30's, I was the 'younger one', so, at times, I worked with the younger bodies, and my colleague, being slightly older than me, attended to

the more mature – the age with which we were most closely aligned. My 30-something body and my colleague's 40-something body were configured and arranged to combine with the textual-body (of the *Care Pathway*) and the physical body that was yet to present at Lyndhurst. In this way, when allocating 'the case', when our counselling appointments aligned, we distributed the body of the client according to age – a number.

Social workers talk of "women" and "clients" but we also framed these service users textually, according to our appointment sheet: "who's seeing the next one", "how many have you seen", "I've done four, so I'll do the next one", "It's quiet, and we've only got three". This is similar for the wider Lyndhurst team as they also articulate the bodies they work with as numbers: "how many have we got on the list", "there's a space on the list", "can we put on an extra", or as rooms "Three bay's just leaving" [the woman in the bed by the bay window], "two window's medicated" [room two beside the window]. Within Lyndhurst, the turnover is quick with approximately 10 patients per day on an operating list who are in from 8am and generally out by 4pm, usually earlier. Other patient traffic includes counselling, social work assessment, and doctor's appointments for first and second certificate and nursing appointments. Names can be literally forgotten, "the one with the piercings". The service user, her story and situation is condensed and compacted and transformed. She becomes numbers, beds, locations, transfers, objects.

Allocating by age (or other markers, needs or resources) is a means to sort the service user as an object through parts of service provision. With regards to the care practices of abortion provision, the behind the scenes work of sorting and allocating the service user is one that engages staff in an object-centred language via words and figures, and staff enter into this dialogue. Should a staff member talk loud enough, or peer behind a door or around the corner, they may come face-to-face with the object of care. When staff come face-to-face with the individual service user, these arrangements call upon staff to engage with the service user in different arrangements. This engagement calls upon staff to act with the embodied service user. However, the texts through which she has gained presence are not done away with. Instead, they hold a further quality as a 'truth' about the body as part of the interactions that ensue. Like Stanley Du Plessis and Austrin (2011) have argued on the topic of risk, documentation can establish truths and facts by stabilising multiple sets of practices that then are not open to conjecture. Similarly, Berg and Bowker (1997) noted that the patient file may be viewed as a "treasure of facts" that is able to provide the information that health professionals require (p. 522).

As the *Care Pathway* circulates across disciplinary boundaries into different sites with varying concerns, it mobilises professionals to act in the specific roles they occupy (Berg and Bowker, 1997). This includes doctors' consultations, where the 'clinical gaze' initially falls upon the textual rather than the fleshy body. As Berg (1996) has argued, the body is produced in such a way through texts that a few pages may locate and reveal the problem to address. Linking back to the notion of an unruly body that can be treated and corrected, it is through text that the details of this body are made transparent. During certain staff-service user interactions at Lyndhurst, the interrelated texts of the *Care Pathway* are momentarily privileged as a receptacle of 'facts' and a mediator of insight into the truth about the patient-body.[74]

Prior (2008) argues that documents tend to hold a dual role – as "receptacles of content" or "active agents", with the former of the two roles taking precedence and downplaying the significant contributions that documents make (p. 822). In the spirit of Prior's (2008) argument, the *Care Pathway* and its interrelated texts are far from inert. Moreover, as Berg (1996) has discussed, the patient file can be viewed as 'conducting' the interaction between the consultant and patient. This active, entangled and interdependent role of the *Care Pathway,* both holding facts and mediating action, is evident in the fieldnotes below:

> *In the consultation room, the doctor engages with the woman by asking about her studies, information that was provided on the GP referral. "So you're studying at polytech? What are you studying?" The woman responds that is studying a recreation/adventure based course. The doctor nods then states that she will read the file and this begins with the social work notes. There are a few quiet moments as she does this. The doctor then asks when the woman's last period was as the woman responds indirectly that it was a while ago. The doctor finds and looks at the scan result in the file and calculates the first day of the woman's last period (LMP) using the pregnancy wheel. Today the woman is 8 weeks and 6 days pregnant.*

As Mol (2008) has explained, "In the consulting room…the body is not silent but a necessary precondition for speech. It is the very entity that speaks" (Mol, 2008, p. 35). The precondition through which the service user is present is to do with her pregnant unruly body. In the doctor's consultation above, when in the talk of the consultation, the date of the woman's last period cannot be ascertained by simply looking at the body; the entity of the body speaks

[74] This articulation of documents and their 'facts' highlights the agency granted to the documents themselves in their legitimacy to represent the body truthfully.

through documentation – the scan result. From the scan result and this account of the inner workings of the body, the doctor is afforded the means to track the date of the women's last period with the use of a pregnancy wheel, a further document, and the current gestation of the pregnancy is determined. In the practices of the doctor's consultation, the inscribed body holds a key role in the work with other actors - the patient in her fleshy form and the doctor. A service user in the interview excerpt below, reveals a further layer of this textual significance:

> I18: She had a look at my file beforehand and like when she was trying to talk to me she was just flicking through it just like you would flick through a book like ten minutes before a test…
>
> (Interview 18)

The service user above speaks to the fissure between the embodied patient and the inscribed patient. Indeed, she states, the staff member was looking at "my file" not "my body". The file is a textual representation of the patient and their body context, and it is the patient file and the information it holds that allows the professional to act (Berg and Bowker, 1997). Neither the doctor, nor the patient, can proceed without the file. One of the tensions from the excerpt above is that the doctor is looking to the file for information and direction over, or in absence of, the narrative of the patient. It is the file that holds the facts. Even though the activities of the doctor's appointment involves relational work between the doctor, the patient-body and the patient file, in the excerpt above the primary site of the body is afforded to the patient file.

The Patient-body: Subject-object Entanglements

As Mol (2002) has discussed, the patient emerges across various sites. The operating theatre is one of these. In the operating theatre there is a focus on particular parts of the body – inevitably, a surgical abortion procedure involves the removal of pregnancy from the uterus. However, even within a site such as an operating theatre, as Mol (2002) has explained, it is not a case of attending only to the body as an object and focusing on the flesh, but there is also a 'switching' between attention to the body and the patient. For Mol (2002), this is evident in the 'switching' between the attention to the arteries in the operating theatre and invoking the patient through the dialogue amongst the medical staff – they switch between repertoires of practices. At Lyndhurst this occurs somewhat differently, where instead of a 'switch' per se, there is a sort of entanglement where, in theatre, the patient is also active in the enactment of

the body. The specific practices at Lyndhurst underpin this difference. Unlike Mol (2002) and the fully anaesthetised body that enable arteries to be treated, the treatment at Lyndhurst does not require this degree of anaesthesia. A different body is evoked, one that is more participatory in the operating theatre – a patient-body.

In this section, observational material and interview data to do with surgical abortion and operating theatre practices are foregrounded. To enter into the practices of the operating theatre, patient-bodies are coaxed into being through relations between actors. The use of the term patient-body is indicative both of the subject-object entanglements of the body (Mol and Law, 2004). This notion is articulated by Latour (2004) below:

> When you enter into contact with hospitals, your 'rich subjective personality' is not reduced to a mere package of objective meat: on the contrary, you are now learning to be affected by masses of agencies hitherto unknown not only to you, but also to doctors, nurses, administration, biologists, researchers who add to your poor inarticulate body complete sets of new instruments… (p. 226).

Drawing on Latour (2004), and his caution against distinguishing between mind and body, we can come to know, rather than define, the body by how it is talked about and how it becomes sensitive to the artefacts it assembles with in an ongoing way. Latour (2005) has argued further that bodies are not 'mere' objects, but they may also be considered as collections of agencies. And these collections are dynamic. As Barad (2007) stated, "Agency is not an attribute but the ongoing reconfigurations of the world" (141 in Suchman 2008, p. 121). The notion that agency is configured and reconfigured is a useful tool through which to consider the body as both subject and object. In this way it is possible to consider how the patient-body is assembled in and through a 'choreography' of agencies.

The term choreography is indicative of the work of Cussins (1998; also see Thompson, 2005). Cussins (1998) offered an interesting view concerning the arrangement of the body and the 'problem' of objectification. For Cussins (1998), objectification is not necessarily an end in itself, but an instrument to achieve particular goals and the dual intentions of getting things done and meeting collective goals of the patient and service provider/staff. While objectification conventionally dehumanizes a subject into an object, there are instances where objectification may be purposeful and even vital to the subjectivity of the patient. In her study of agency for female patients in a fertility clinic, Cussins (1998) has argued that women may retain agency when they actively participate with physicians to objectify and 'un-black-box'

the body to make visible parts of the body as part of a treatment cycle, with the goal of changing their infertile identity.

The goals of service users at Lyndhurst are inverse to those which Cussins (1998) describe, but the notion of agential choreography is of interest to reveal multiple modes of ordering the body and the human and non-human actors involved in the emergence of a patient-body. The gathering space of the operating theatre, the positioning of the body on the table, and the vocal contributions of staff and the patient-body in theatre, requires that the service user enters into an interdependent arrangement with spaces, technologies, materials, and staff to meet the mutually constituted goals of both the service user and health professionals - to achieve a surgical abortion procedure. What is also achieved from these spaces and sets of practices is a patient-body. A patient-body that is both subject and object, that is both treated and participates in care practices formal or otherwise.

(Re)Arranging a Body for Surgical Abortion: Numbing and Draping

Subject-object entanglements are not always evident in accounts of theatre practices. In some accounts of operating theatre practices, the patient is turned into a body by the use of anaesthesia (see Hirschauer, 1998, p. 20). This presents a reduced patient-body where the anaesthetic puts the patient 'to sleep', and during which the selfhood of the patient is put aside for a time as the fleshy body comes to the fore. Consequently, this version of the body is rendered passive. The patient-body at Lyndhurst is a less disciplined patient-body than that of Hirschauer (1991) in his account of manufacturing bodies in surgery. With surgical abortion at Lyndhurst, anaesthetic is localised rather than general. This produces a different type of patient-body in the operating theatre than that of a fully anaesthetised body.

> *The nurse at the head end is talking. She is working at the site of the woman's hand where the line is. "I'm going to give you some fentanyl. It might make you feel a little lightheaded but it's also good for pain relief". She is holding the woman's hand and checking the monitor. She asks the woman occasionally if she woman is ok and explains what is happening. The doctor is going to start the procedure now. The doctor positions herself at the tail end of the bed. She tells the woman that she is going apply some antiseptic solution to the vaginal area. The sheets covering the woman's lower body are lifted away. The doctor and nurse then drape leg covers over the woman's legs and a large sheet with a triangle gap is placed over the woman's pelvic area to cover the area except for a gap to work through.*

In preparation for care and the treatment of abortion, parts of the body are isolated with task-specific sheeting that obscures some aspects of the body and reveals others. In a similar way to Hirschauer (1998) and his discussion of the arrangement of bodies in theatre for sex change surgery, the sheeting that is used in theatre at Lyndhurst is arranged in a certain way where "private parts" are made public, and visually "dissects" the body prior to the surgical procedure (p. 21). This arranging of the body is necessary for other actors to undertake their tasks.

> *The doctor picks up a speculum from the trolley. Her site of work for now sits there on the table, within a triangle of fabric. The doctor inserts the speculum smoothly into the vagina. Then, she picks up another tool, a slender clamp which she uses to clasp and secure the cervix. Next, she picks up a syringe of anaesthetic from the tray and injects the right side of the cervix and then with a second syringe, injects the left. Stab, stab. I feel my pelvic area contract but the woman on the table does not flinch. Another doctor tells me later that the nerve endings on this part of the cervix are sparse, not like the nerve endings on the back of your hand. At the woman's head, the nurse is engaging the woman in conversation and she is chatting about her living arrangements and a recent trip away.*

In theatre practices at Lyndhurst, actors work to prepare the patient-body. Non-human actors – drugs – are required in order for other actors to do their work. On the ward, pills have already been added to the patient-body in order to soften the cervix. Now in theatre, local anaesthetic is added to this arrangement in order for instruments to open the cervix and further prepare the patient-body. Moreover, the self-aware body of the patient is disrupted with sedation, the fentanyl. This sedation has an impact on the body but does not eliminate the participation of the patient. The body is made drowsy with fentanyl but this drug does not render the body asleep. Further, local anaesthetic that is injected into the cervix works to 'numb' this particular part of the body as a preparatory part of treatment. This body in varying degrees is all at once aware, sedated, and partially anesthetised. It is a body that is changed in multiple ways, but it is not 'put to sleep', made passive, and does not turn into a body as in Hirschauer's (1998) account of a fully anesthetised body. Moreover, the awake patient-body is talked *with* rather than talked *about*, as was the case for anaesthetised bodies in an earlier account of Hirschauer (1991). Here, it is possible to consider the patient-body as a kind of 'choreography' of agencies (see Cussins, 1998).

In the theatre practices at Lyndhurst, the local anaesthetic does not impose a firm boundary between the body and the mind. They are not separated out but remain integrated. In this

way, the body in theatre at Lyndhurst is active. However, because of the sedation, this drowsy body is active within limits, as the following actor explains:

> I39: … the fentanyl in that situation it made me feel quite out of control and quite odd…probably what I remember most is them telling me to lie down on the bed and I couldn't even think whether I had to put my hands down, and my legs…it was just an out of control feeling. You can hear the instruction but you couldn't think how to carry it out.
>
> (Interview 39)

In this way the body remains active in certain tasks that precede treatment. It is possible then to acknowledge the abilities and capacities of the body even, and especially in the arrangements and asymmetries of this mode of care. In the work between the service user, the staff at Lyndhurst, and the operating table with its leg-holder appendages, the body moves into position in order for the abortion procedure to take place. The body is sensitive to the activities of theatre, moving in response to direction and treatment. The management of the body is a collaborative effort. However, in this set of arrangements, there remains a tension concerning the distribution of agency between these various actors.

Figure 3. Operating Theatre. Photo: Maria Buhrkuhl

As a focal point for surgical abortion practices, the operating table enrols the service user who must place her body upon the table for the procedure to be performed. To combine with the table, the service user must lie on the operating table on her back in the lithotomy position where her knees are bent and spread apart, rather like a supine crouch. Because the service user cannot maintain this position on her own, she is directed to place each leg in the 'leg supports', or stirrups to hold the weight of the bent lower leg – a slightly curved 'shelf' for the lower leg to rest on. Moreover, the service user must shuffle down. The nurse explains the sensation of this, like your bottom is going to fall off, but reassures the service user that this is a right position. The enmeshment of the operating table and the service user is a necessity and a normativity of surgical abortion, and many other procedures for that matter.

In her account of the role of the electric wheelchair for people with disabilities Moser (2006) demonstrated that tasks can be distributed and delegated from human to non-human actors. With surgical abortion, the task of 'presenting' the body is not afforded only to staff or the service user, but is consequently delegated to the operating table with its stirrups. Rather than lie upon the table as if these actors were distinct, the service user must combine with the table. Here, we no longer have an operating table nor a service user, but a patient-body arranged for a surgical abortion procedure.

> *At the end of the table the nurse on tails explains to the woman what she is doing. "I'm just going to cover you now". She pushes the sheets between the woman's legs to cover her vaginal area. "I need you to put your legs in the leg supports". The woman hesitates. The leg supports are placed so that the woman lying back on the bed will be in the equivalent of a horizontal squatting position (lithotomy). I imagine it is quite an ask to position oneself like this. The woman places her legs in the leg supports. The nurse explains further "I'm just going to drop the end of the table down and you might feel like your bottom is going to fall off the edge, but this is the right position" as she drops the end of the table down 90 degrees. And the bed is tilted raising the bottom end of the bed and lowering the top. The nurse shifts her focus back and forth between the tasks of the body and to talk with the woman on the table.*

The foregrounding of the body, or rather parts of the body in the arrangement of the body for surgery, lends itself to Cussins (1998) concept of choreography where the body is ordered and reordered to achieve specific goals. For Cussins (1998), objectification was revealed to hold possibilities for the service users in a fertility clinic who actively and temporarily participated in the objectification of their body, like the example of the arranging of the body on the table

above, in order to achieve change. Like Cussins (1998) notion of bodily choreography, neither objectification nor agency is static, stable, assumed or permanent, but occurs in the continual negotiations between invested human and non-human actors.

Once the operating table is set up, it does not tend to move. Accordingly, the movements of the patient-body are also restricted. In the assemblage of the operating table, the patient-body is being treated and monitored. The height of the patient-body is lower than the multiple medical staff in attendance, and is located in the centre of the room, a focal point - surrounded by medical professionals.[75] The operating table reproduces asymmetrical power relations between the actors of Lyndhurst and the service user who enters this setting. For the doctor who is at the end of the table and between the legs of the service user, a body in lithotomy offers good physical and visual access to the pelvic region, the region that is key for enacting a surgical abortion procedure. Yet, lithotomy is not a position that one might routinely assume, and the arrangements and apparatus of theatre may be unfamiliar, as the service users below describes:

> I33: …they just maybe assume…I've never had my legs put in stirrups before, do you know what I mean …so many surprises…I was shocked at the number of people that are in there…I wasn't allowed a support person in theatre so I felt like I had to do it on my own… And, um, I don't really like not being able to wear my own clothing, I suppose if anything does go wrong, but I didn't like that gown thing. That was a loss of control as well.
>
> (Interview 33)

The network of care that produces the patient-body in the operating theatre is mobilised by human and non-human actors at Lyndhurst. This involved the exclusion of support persons from the patient-body assemblage, as a means to focus on the patient-body and mitigate unanticipated disruptions. "It [theatre] is not a familiar environment for most people and we can't be supporting the support person if they get upset in theatre" explained one of the nurses. Further to the exclusion of a support person from the assemblage, personal clothing is excluded from the patient-body assemblage, and instead a blue hospital gown is included.

Latour (2004) has referred to the body as "an interface that becomes more and more describable as it learns to be affected by more and more elements" (p. 206). The patient-body

[75] In this way, the arrangement of the table, the service user and staff, lends itself mechanisms of control and a form of Foucauldian (1975) hierarchical observation.

is 'affected' by the addition of the medication, the draping, the operating table, and now the hospital gown. With the addition of the hospital gown, the patient-body is visibly differentiated from staff. Theatre staff are dressed in blue scrubs, loose drawstring pants and V-neck tops, while the service user wears a blue gown. Staff in theatre wear coverings on their footwear like blue shower caps for shoes. The service user wears socks - to keep warm. The notion of warmth lends itself to both subject and object realties, as the following section attends to.

Warmth: Distributing Subjectivities

Pols and Moser (2009), in their analysis of robot pets and telecare practices, argue that 'cold technologies' and 'warm care' need not oppose each other. When technologies "bring something of value to the user", then users can be coaxed into engaging with these technologies and specific modes of care (Pols and Moser, 2009, p. 166). Similar to the argument of Pols and Moser (2009), staff seek to 'bring something of value' to service users at Lyndhurst through the entangled human and non-human assemblage of *warmth*. Through this assemblage, there is an attempt to 'make things better' when it comes to the service users trajectory through the practices of theatre.

For staff, the apparatus they engage with, where they stand, and their proximity to various parts of the body, offers clues to their roles. Private colloquialisms amongst nursing staff indicates their work with a specific part of the body. 'Tails' indicates the 'bottom' end of the body, the pelvic region, while the nurse on 'heads' is unsurprisingly located at the head of the body. By being responsive to the wording of the actors, we are not talking here of the person as a whole, but a body that is divided into regions that subsequently delegate the tasks of work for nursing staff in theatre. Without saying a word, the body activates divergent theatre practices. At the same time, this splitting of a collective of nursing staff in theatre to attend to various parts of the body, attends to the patient-body as subject and object. Combining the distribution of nursing tasks with the materials and technologies of the operating theatre are key to enacting a patient-body.

> *The nurse at the head end of the operating table assists the woman around to the left hand side of the table. She says "just pop your knickers off, no one's watching and we'll just pop them under the pillow". She tells the woman to "hop up" on the somewhat long narrow table. The table is draped in a white sheet. There is a pillow at the head end. The nurse attaches the clip of the pulse monitor to the woman's finger. All the while, the nurse on tails and the doctor are chatting. The doctor is scrubbing her hands*

and the nurse is busy with the trolley. The nurse retrieves the iodine slosh from a container of warm water, "so it's not freezing cold" another nurse tells me, and pours the slosh into one of the bowls. It will be used to cleanse the woman's vaginal area at the start of the procedure. The doctor sets about putting the line in the woman's hand, tapping around the hand to get a vein. Then, the nurse on tails tells the woman to lie back onto the table and shuffle down the bed towards her, "keep shuffling down, I need you to shuffle down". The nurse on heads places one of the warm blankets over the woman. "It's warm isn't it" she says. The woman nods, "Yes, it's warm". The nurse continues, "I'm just going to get you to put your arm out on the board here" as she adjusts the arm rest on the right hand side of the bed.

The nurses busily work with the patient-body using their own bodies where they engage both voice and touch. They relate to and include the patient-body in theatre practices by weaving into their activities with the body a verbal account of their tasks. There is a makeshift effort to afford the patient-body privacy – "just pop your knickers off, no one's watching". This effort occurs in the presence of relatively unfamiliar others although this obscuring of the private parts of the patient-body will later be reversed when her body will be intentionally and necessarily revealed as part of the abortion procedure. In this moment, however, exposure is not necessary and privacy is prioritised. There is attention to warmth. The sensation of warmth, socks on the service user's feet, the heated blanket and slosh, and more abstractly, the pillow that knickers get tucked under, all play a part in not merely attending to the 'body-object' (Mol and Law, 2004) but also the subjectivity of the service user.

The subjectivity of the patient-body is articulated as human and non-human actors are included into this assemblage. Materials are literally warmed. But warmth also includes the voice and the actions of staff. The nurses are friendly and efficient. They speak informally. The language of science and medicine is absent as the service user is directed to "pop knickers off", "hop up" on the table, and "shuffle down", before getting the patient to put her "arm out on the board". The presence of wording is entangled with the materials and hands that attend to the care of the body. Another nurse explains:

I1: … if you can make it just that little bit better for somebody, in whatever way, whether that's emotionally, physically, or what have you then I would try and do that…like particularly if you were doing tails [assisting the doctor performing the abortion as opposed to supporting the patient at the patients 'head'], you didn't have a lot of patient contact, but even doing that role, being conscious that you are going to

> expose those patients and aware of the fact that, you know, that they don't feel like they are being exposed over a long period time – you keep them covered as long as you can, you explain you know that you're going to lift their legs up, you don't just go and whip them up or whip them down. If you need to wipe them or anything like that you say to them, "Is that alright with you?" And just remembering that they are still a person...
>
> (Interview 1)

The patient-body as both subject and object emerges from the weaving together of many different actors and practices. The interwoven work between nurses, service users, wording, materials and the sensation of warmth 'acts back' on the notion that those who enter health settings may be merely objectified (Latour, 2004).

Mol (2008) offers the term "patientism" to depict the active patient that need not be silenced but allowed to exist (p. 31). I draw from this notion in a literal sense, where the patient-body is assembled as both subject and object that is further articulated through verbal exchanges in theatre. 'Vocal local' is the term for some of the verbal exchanges and emphasis on relational work that helps make the abortion procedure manageable for the patient-body by reducing anxiety, distracting from pain, and seeking to avoid pain where possible (Bates, Keogh, and Ngo, 2013). The term 'vocal local' is an intangible play on the tangible local anaesthetic that works on the body - it is a 'supportive anaesthesia' (Bates, Keogh, and Ngo, 2013).[76] Below we are alerted to the addition of verbal support to the assemblage of the patient-body where discomfort during the dilation of the cervix mediates the nurse to deploy a 'vocal local' technique.

[76] The technique emerges from the sphere of medicine and emphasises talk for its therapeutic value, although the evidence based literature that support the validity of "vocal local" as a technique is scarce. The social workers I encountered during a presentation about 'vocal local' at the 2008 Abortion Providers Conference argued that this "vocal local" is nothing new, and the relational work with service users to ameliorate anxiety and pain is elementary to their role. "That's just what we do" stated one of my social work colleagues. However, the value of relational work with the body through talk cannot be taken for granted as routine in different arrangements of care. Bates, Keogh and Ngo (2013) draw attention to what might be assumed for the social workers I encountered when they state, "Vocal local is a continuous process, starting when the woman enters the clinic, continuing into the consultation, the procedure and the recovery right through to being discharged" (p. 2). Thus, the formalisation of vocal local may be argued as recognising the integration of the body rather that the body-object that traditionally formed the focus of care.

The doctor inserts the uterine sound to check the length of the uterus. "Can I have a twelve" she asks the nurse on tails who will retrieve a cannula of the correct size for the procedure. In the interim the doctor starts to dilate the cervix, inserting the dilators starting with the most slender. In through the centre of the cervix and out. In and then out. A small gap begins to appear. The last two or three seem uncomfortable for the woman. I hear the nurse at her head say "just one more, just one more, breathe deeply – in through your nose and out through your mouth, that's it".

As indicated above, the patient-body is receptive to the technique of 'vocal local' in theatre. The patient-body can hear, process information, and act accordingly – for example, by breathing deeply as noted in the excerpt above. In addition, because the patient-body is awake in theatre, it is able to contribute to the conversation in theatre add to these verbal exchanges. Further to the management of a patient-body in pain, the everyday stuff of life made its way into the conversations in theatre. As a service user below speaks to this:

I47: What I remember about having it done was the conversation of planting rhubarb. The nurses were all talking about planting rhubarb!

Letitia: And was that yours or their conversation?

I47: It was the conversation that they were having so I joined in and said my parents used to have rhubarb plants at home that the boys all peed on!

Letitia: And how did it feel for you that this conversation was going on?

I47: I thought it was actually quite a funny conversation to have! And so they just told me to hop up onto the bed and everything got done and we're all just giggling and carrying on about rhubarb and the nurse next to me started talking to me about my kids or something and the next thing I knew, it was all over – the IUD was in place and I could go back to my room.

(Interview 47)

The patient-body is enacted in and through relational work between human and non-human actors. There is no one way in which this takes form. Above, in the operating theatre, and in the assembling of the patient-body, there is banter about rhubarb. Just as readily, I observed topics such as family, study, work or recent events as vehicles for the vocal support that the nurse offered. Moreover, in my observational role, such as observing the practices of theatre,

the 'patient' is not merely observed but becomes a co-author of abortion practices in theatre. If the patient was under a general anaesthetic, this would be omitted. Further to this, she is able to reflect on this experience later in the arrangements of the interview, and relay the nature of the conversation to me. In this way, she is not only active in theatre, but resurrects this active-ness retrospectively.

Subject-objects arrangements are generated momentarily and are contingent upon how different sets of actors and practices gather together.

> I33: I'd asked them just to leave me alone, I didn't want anyone touching me or beside me because it would distract me from my own way of dealing with it.
>
> Letitia: Because you were using meditation
>
> I33: Yeah and I didn't want to be distracted out of it
>
> Letitia: And was that effective?
>
> I33: Yeah, except when I started to shake I think she thought I might need help and of course because I was in that environment I was really on edge and I just barked at her and said "leave me alone" because I just find someone else comforting me in a situation that I'm handling, I just don't need it. So, yeah and they respected that.
>
> (Interview 33)

As is the point of vocal local, when nurses talk to the service user and she is responding, then her participation in the conversation may distract from the treatment on the pelvic area and the challenge and pain this may involve. While this may be useful for some service users, other service users talked about the annoyance of being talked to, and said that they wanted to manage the treatment of abortion on their own terms. In this case, the vocal efforts were an unwanted distraction. This is the case for the actor in the quote above who sought to engage a practice of silent meditation.

Conclusion

By presenting the body as multiple, several reconciliations are presented that surpass the notion of abortion and indeed the body as singular. Firstly, the different versions of the body that have been presented show the translation that is necessary in order to coordinate the

trajectory of abortion provision. A pregnant-body must be translated into a textual-body to mediate entry into service provision. Eventually this body enters the operating theatre where the patient-body is assembled. Different sites and practices produce different body realties. However, I concur with Mol (2002) in viewing that the body that is part of an abortion assemblage if not fragmented.

Borrowing from Mol (2002) and her attention to multiplicity, I have attempted to show that within the assemblage of abortion the body is also assembled in different versions. This occurs through the work of human and non-human actors within different sites, both within and beyond Lyndhurst. The body of the service user is not fixed, but undertakes reconfigurations through which different capacities of the body emerge and contribute to the circulation of the body through abortion provision. Through these configurations, the body is revealed as neither an object nor a subject, but as combined object-subject realities. The body is whole but not singular. The body is organised but not compliant. The body is acted upon but is not passive. The body travels physically but not only within its physical parameters. The body that is pregnant, textual and active, is also purposeful in that it assists the movement through varying obligatory passage points to meet particular goals. Bodies of care are embedded in treatment practices – not trapped in deviances, paternalism, or even emancipated (Mol, 2008, p. 38). Further, bodies may intervene in the practices they are embedded in. In this way, the conventions of a passive object of a medicalised body is reclaimed.

Chapter Six: Making Things Move: Decisive Moments and Circulation in Abortion Provision[77]

Introduction

In the previous chapter, versions of the body were discussed by drawing from Mols' (2002) notion of multiplicity. The textual-body in particular offered clues to how a body might begin to circulate through the service. As noted in Chapter 5, *The Lyndhurst Hospital Multidisciplinary Care Pathway (*patient file) is the service documentation that both guides and accounts for the collective work of abortion provision. The term 'Pathway' infers a course of action that occurs on a linear continuum from one point to another. What is obscured in service documentation is the sets of practices and the relationships between actors that enable the circulation of the service user. Following some of these 'translations' is the key focus of this chapter.

Translation is a concept that is central to ANT research. Best and Walters (2013) have stated, "To translate is to establish relationships of equivalence between ideas, objects, and materials that are otherwise different…[y]et it has to be stressed that in any moment of translation, there is always an element of transformation and perhaps betrayal" (p. 333). Law (2009) also captures this notion when he articulates that translation is on one hand about making divergent world's equivalent, but at the same time, this involves links that shift and change these worlds. In this way, while this chapter accounts for the relationships and reconciliations that allow a trajectory of abortion to move, it also attends to some of the tensions and compromises that are inevitable when divergent worlds combine.

At Lyndhurst, sets of practices that concern the movement of each service user, the work of Lyndhurst staff, and the contributions of various technologies are inscribed (or traced) in, and through, various *inscription devices.* An example of this was presented in Chapter 5 where the pregnant-body was transformed from fleshy reality to a textual form. In this chapter, various

[77] The heading for this chapter deploys a phrase "decisive moments". French street photographer Henri Cartier-Bresson used the expression "the decisive moment" to denote the capturing in a photo of a potent yet fleeting moment in often ordinary interactions. Within Lyndhurst, the interactions that take place to comprise abortion provision are also often ordinary to staff who repeat the sequences of their work often in their day to day practices. Yet, these too involve potent decisive moments and culminations that are captured not in photographs but through other inscriptions.

documents, test results, scan reports, Certificates,[78] and teaching devices and their human counterparts – such as the doctors and service users - participate in translating the messiness of the world into a usable mobile object (Best and Walters, 2013). Accordingly, an inscription device, similar to those in the previous chapter, is "any item of apparatus or particular configuration of such items which can transform a material substance into a figure or diagram which is directly usable by one of the members of the office space" (Latour and Woolgar, 1986, p. 51). Here Latour and Woolgar (1986) refer to the scientists in the laboratory, yet, the 'laboratory', 'office', or other spaces of work are just as readily configured elsewhere (Latour, 1999). An inscription device can be a material thing like an instrument, machine or a technology, but it is not confined to this. An inscription device is also a "set of arrangements for labelling, naming and counting. It is a set of arrangements *for converting relations from non-trace-like to trace-like forms*" (Law, 2004, p. 29, emphasis in original). "It is a set of practices for shifting material modalities" (Law, 2004, p. 24). This chapter seeks to show some of the ways in which messy and diverse abortion practices are 'packed' into inscriptions.

The version of translation that I have primarily followed draws from Latour's (1999) notion of 'circulating reference'. Latour (1999) argues that, when "we pack the world into words", this occurs through a series of translations or movements (p. 24). From his inclusion on a fieldtrip to Boa Vista in the Amazon Forest, Latour (1999) describes the method of scientific inquiry which accurately but selectively represents the forest and the savanna in such a way that specific relationships become visible. The translation of the field into a document can stabilise a network – turning it into an immutable mobile – when the field is translated into paper (Latour, 1999). An immutable mobile, like a research article, is an object of both permanence and mobility that can be readily interpreted by different actors regardless of the specific context.

However, this stability does not happen without a great deal of work. In talking about tree specimens on a worktable, Latour (1999) noted "In passing directly from the field to the collection, I must have missed the decisive go-between…In actual practice, however, one never travels directly from objects to words, from reverent to the sign, but always through a risky intermediary pathway" (p. 40).

Through various devices, such as a gridded box that holds samples of soil (a pedocomparator), and the tagging and selection of tree specimens, the 'stuff' of the savanna/forest border is

[78] The capitalised 'C' in Certificate is intentional and follows the formatting of text of this word on the Certificate itself.

sampled, transported, and rendered into an increasingly more mobile and textual form. Moreover, the circulation of 'things' involves combining and recombining – accounting for this involves making clear all the mediations that allow the writer to make reference and describe the world (Latour, 1999).

The notion of circulating reference when applied to abortion concerns thinking about how it is necessary to move from one point to the next in an abortion trajectory, and at the same time, if we are to talk about abortion, then we are talking about all of these components at once. Abortion, then, cannot be pinned down to one correspondence or one relationship. Instead, what we are dealing with is a chain of end-to-end practices. This chain of practices links and moves through a series of decisive moments. Like Latour (1999), I have sought to examine in detail the practices that produce information about a state of affairs as this occurs as a circulating reference.

I start this chapter by drawing attention to the home pregnancy test – a little device that, in addition to the hormonal messengers in Chapter 5, contributes to producing a pregnant-body. The pregnancy test does this by sampling the hormones within the body and turning these into symbols. In turn, these symbols are translated further when they represent pregnancy and 'give voice' to what is going on inside the body. Whilst a pregnancy test may make the state of pregnancy externally visible on the test stick, this alone does not provide what is required to enter an abortion assemblage as a pregnant-body. Thus, further inscriptions are necessary. Circulation is only possible when actors connect with other actors and form a chain of end-to-end practices (Latour, 1999).

Consequently, I turn to ultrasound scanning practices, the practices that make a pregnancy that is inside the body externally visible in different ways than the pregnancy test, which merely provides a positive or negative result. Further translation is required. The addition of an ultrasound scan can determine the gestation of a pregnancy and thus the means to access an appointment at Lyndhurst and the prospect of either a medical or surgical abortion procedure.[79] However, devices can act back. For example, if the pregnancy cannot be detected, then the pregnant-body is left at an impasse and must repeat this set of practices in order for the pregnancy to be 'seen'.

The trajectory of the pregnancy takes a different turn in the next section, where I attend to certification and how abortion is authorised at Lyndhurst. This is a process of overlaying

[79] At Lyndhurst, medical abortion was performed up to 63 days gestation, and surgical abortion generally between 8 and 12 weeks gestation.

divergent worlds where the service user, doctors, and legislation must come to an agreement about authorising an abortion. Here the inscription of the abortion Certificate guides the doctor to amplify and reduce the narrative of the service user in order to translate this narrative into the text that the Certificate requires.

The final section follows the translations that occur with the enrolment of 'teaching devices'. Products of conception, a light box, an image from the internet, and a petrie dish all play a part in the 'chains of action' through which staff acquired knowledge about medical abortion – a new mode of service delivery discussed in detail in Chapter 7. The referencing of inscriptions with pregnancy materials in the sluice room are key to learning about what staff must look for to determine if a medical abortion procedure is 'complete'. This sample of 'the pregnancy' in the sluice room is seen to 'stand in' for the other pregnancies that staff will encounter in their work.

Diagnostic tools: Sampling and Visibility

As discussed in Chapter 5, it is unruly pregnant-bodies that come to be enrolled in the abortion network. In addition to the registering of signs and symptoms that hormonal messengers have mediated, further sets of practices contribute to the establishing of a pregnant-body. Home pregnancy tests and ultrasound scans sample the body and make pregnancy more tangible. Whilst the body has become pregnant through various activities, such as the actions of fertilisation, a pregnant-body needs to be assembled and be visibly accessible before it can circulate new networks, such as through the various healthcare settings including service provision at Lyndhurst. Pregnancy tests and ultrasound scans are important mediators of this circulation. They sample the body and translate this sample into symbols, images and texts that provide a version of the pregnant-body that is accessible in material form.

Latour's (1999) notion of circulating reference offers a way to describe this translation of a possibly-pregnant-body to a pregnant-body. In Latour's (1999) study, various devices enabled the site of Boa Vista to be sampled, made visible, and transportable beyond the site itself. The *pedocomparator* is one of the material devices that Latour (1999) includes in his account to demonstrate this process of translation. The pedocomparator is a draw-like grid of cubes that is used to house different samples of the soil (Latour, 1999). The matter of soil samples provides a representation of the types of soil present at the interface between the rainforest

and the savannah. Back in the laboratory, the soil sample provides a condensed version of the soil of the rainforest/savannah, and could be referred back to to reference this site and the soil that remains there. In a similar way to the functioning of the pedocomparator, the home pregnancy test and ultrasound scanners can 'sample' the pregnancy and translate this sample into a visible stable form, thus producing further nuances to the assemblage of the pregnant-body, and provides the means to make this circulate within abortion networks.

The Home Pregnancy Test

One of the most prolific devices that mediates a pregnancy diagnosis is the home pregnancy test. This low-tech device offers a tool from which to take a sample from the body in order to make pregnancy visible in the results that the test produces. Home pregnancy tests are a self-diagnostic device - a publically accessible reproductive technology.[80] Instead of gathering clods of dirt that show changes in the state of the soil at the border of the rainforest and savanna, the pregnancy test collects urine from the body of the woman who suspects pregnancy. The function of the pregnancy test requires the woman to arrange a test strip to come in contact with a mediator, the woman's urine, which the strip absorbs. The pregnancy test is designed to detect human chorionic gonadotropin or hCG. This is present in the urine of pregnant women after a fertilised ovum has implanted in the uterine wall. It is from around the time of amenorrhea or a missed period that the level of hCG is high enough for the test strips of the pregnancy test to detect this and yield an accurate result. When the test is used, and after a waiting period of usually several minutes, a visible result is revealed in lines, shapes/symbols, or words that represent a positive (pregnant) or negative (not pregnant) pregnancy test result.

Like the pedocomparator, the pregnancy test not only makes things visible, but acts as a transporter. The pedocomparator can be folded up like a suitcase and transport the samples of soil. Similarly, as a transporter, the pregnancy test is a mobile device that can be transported with its sample of urine and the results it has yielded. Much like the soil samples of the forest/savannah, once the pregnancy, present as urine, has been sampled by the pregnancy test, the pregnancy is no longer merely located in the flesh but also in the technologies it has combined with. In this way, pregnancy exists in a different configuration in these different co-existing networks. As a reference, it is possible to point to the pregnancy by pointing to the

[80] Accounts of urine analysis feature in ancient history and was of interest to many cultures, yet, the recognition of hCG in urine and its relationship with pregnancy was not determined by scientists until the 1920s (Leavitt, 2006). The development of related pregnancy testing and tests enabled this technology to shift from the laboratory to the doctor's office during the 1960s, and it has only been since the 1970s, when the sensitivity, sophistication and accuracy of the test improved, that the pregnancy test was able to be located in the private sphere of the home, and its status began to shift from "novelty to norm" (Leavitt, 2006, p. 317).

test, as the soil in the pedocomparator allows the expedition members to point to the forest/savannah because of the samples and transformation it has afforded.

The pregnancy test does not have as many compartments as the pedocomparator, nor does it occupy the same space. It takes one sample of the body, rather than many samples of the soil, and its diminutive size is similar to that of a ballpoint pen, rather than the size of a drawer. However, it too provides an example of transformation, of the shifts that can occur from one state to another that enable circulation. To be clear, a positive pregnancy test does not necessarily link to the assemblage of abortion – in fact, most often it does not. However, as discussed in Chapter 5, the unruly qualities of a pregnant-body is an entry-point to the abortion network at Lyndhurst.

Following the informal diagnosis afforded by the pregnancy test, the unfolding of events continues. The significance of the home pregnancy test and the cluster of practices through which it was relevant may fall away as new relations begin to come to the fore when the pregnant-body continues along a trajectory. This may be a visit to a GP, and for some of these pregnant-bodies, a referral to Lyndhurst. And for prospective service users of Lyndhurst, on their way towards entry to the service, they encounter different devices that produce different effects. The pregnancy test is just one part of a series of translations or movements. As Latour (1999) has argued, it is the linkages between practices that enables circulation. The pregnancy test can only travel so far.

Like the pedocomparator, a home pregnancy test may be thought of as belonging to that which is material. It is a tangible object with physical substance. However, because of the design of the pregnancy test and its combining with the body, its material composition can stand in for something else. It becomes a hybrid because of its transformative qualities that may reveal a pregnant-body and make this bodily state visible – a confirmation that pregnancy is present in just a few lines, or perhaps a '+' or a '–' that indicate positive (pregnant) or negative (not pregnant test). In this way, the pregnancy test is also a 'sign' – a device that carries meaning beyond its physical form. In this case, the production of symbols on the pregnancy test are not mere symbols, and the end to this transformation, but are the symbols that represent and make reference to the pregnancy.

The limitation of the pregnancy test is that it cannot provide more detail than the lines or symbols it offers to indicate pregnancy. The test mediates the presence of pregnancy, but it does not reveal the gestation of the pregnancy or its duration thus far, the due date, or the size of an embryo or foetus. This device needs to 'handover' to other devices in order to further

assemble the pregnant-body. As Latour (1999) argues, "a single inscription would not inspire trust" (p. 28). The overlay of multiple inscriptions, or in this case, the multiple devices that assemble pregnancy, are required to provide further information about the pregnancy-body.

Scanning Practices: Time and Measurement

A new kind of visibility of the pregnancy is required beyond that of the pregnancy test – one that is derived through taking images and precise measurements. Again, I make links to Latour (1999) in order to unpack this new kind of sampling and visibility.

In Latours' (1999) circulating reference, the trees of the Amazon forest were tagged - tin tags attached with a rusty nail marked the trees at various coordinates of the site in order to map and track the forest. Specimens were taken from the trees in order to reference the forest and make links to the forest as a whole (Latour, 1999). Similarly, the practices of ultrasound scanning 'tag' the pregnancy and map this part of the body. Moreover, when the radiographer measures the pregnancy, and later when staff at Lyndhurst point to the scan result, they are, for all intents and purposes, pointing to the pregnant-body as a whole.

With ultrasound scanning, the pregnancy within the body is selected and isolated and becomes observable in 'real time' on the monitor to the radiographer. It is made larger into an image in order to be measured and reconfigured into numbers. This translation of a moment that is captured and fixed in weeks and days in a report is the version of pregnancy that is part of abortion networks. It is the reference that is required in order to enable the pregnant-body to circulate.

Like the home pregnancy test, the ultrasound scanner becomes a hybrid because of its transformative qualities. The ultrasound scanner may reveal a non-pregnant body, or a pregnant-body, but this device goes further to provide a particular gestation and make this bodily state visible. This builds on the pregnancy test that only provides a '+' or a '–'. But, the ultrasound may not secure complete trust. It may also reveal further bodily unruliness in the form of an ectopic pregnancy, or multiple pregnancies. This transformation offers a reference to, and also an abstraction of the pregnancy within the body. The pregnancy in its three-dimensional reality within the uterus is changed to a two-dimensional textual form. Measuring a pregnancy according to weeks and days locates this entity on a continuum of time, and time is all important within restricted parameters of abortion provision (Silva, McNeill, and Ashton, 2010).

It is the scan result that mediates certainty and when an appointment may be accessed. When medical abortion started at Lyndhurst, the gestation of the pregnancy was required to be no more than 7 weeks and 6 days on the date of starting the procedure.[81] Surgical abortion typically occurred between 8 and twelve weeks gestation. What was sought from the intervention of an ultrasound scan was a certain classification of pregnancy. For admission to the abortion service, Lyndhurst did not seek an image, a version of the pregnancy that the scan can offer, but a pregnancy that had been objectively measured by gestation and turned into a report with a number, a pregnancy conceptualised in terms of weeks and days (Mol and Berg, 1998).

Within pregnancy ultrasound scanning practices, implanted embryos and developing foetuses are visually externalised from the body of the pregnant woman. To do this, an ultrasound machine sends inaudible high-frequency sound waves through the body via a transducer (camera) where most of these sound waves are reflected back from the tissues of the body. A series of moments that interpret these echoes as images provides a picture on a monitor (Strathern, 2002). This interpretation of the body calls for further interpretations by a radiographer (Strathern, 2002). It is the radiographer who takes a measurement from the image provided. In the scanning practices for Lyndhurst, there is a particular manner in which this may be conducted:

> I17…our actual scanning is exactly the same, babies the same, and you're still assessing the uterus and the ovaries. But if it's a termination scan, we turn the TV off - the TV that's behind us, that the patient can see. And I often will turn my monitor on a funny angle so that is can't be visualized by anybody in the room…if it's a dating scan and they're embracing the pregnancy, you have the TV on and you probably talk about the baby…but with a termination pregnancy we absolutely would never say anything like that…And so I scan… measure it very quickly and this would take 30 seconds to a minute to flick through and make sure it's not a twin pregnancy, have a look and see that it's pretty normal, that the sac's in the right place in the uterus and measure baby from head to bottom, give us the dates, then flick out make sure the ovaries are ok and then we're done…And some of them will ask, "well, how far along am I", and I say "you're 10 weeks", I don't typically tell them "if you continue with the pregnancy, your

[81] Later this changed to an upper limit of 9 weeks gestation.

> due date will be…", I wouldn't tell them that with a CT (consideration termination) scan, I'd just say "you're 10 weeks at the moment".
>
> (Interview 17)

At the radiography service, the scanning practices are mediated by an acronym. The radiographer refers to the "CT" scan, a code on the referral form for the scan that indicates that the service user is considering termination. For a CT scan the wording that the radiographer above uses is different than for a dating scan where this pregnancy is referred to as a baby and where a due date is provided. With a CT scan there is no such wording, or rather there is an absence of wording that affords this detail. With a CT scan, the trajectory of the pregnancy is not enduring. Rather, wording is temporally sensitive to the present. As the radiographer in the quote above indicates, she would say something like, "you're 10 weeks at the moment".

Through the arrangements of apparatus, the service user is on the margins of the tasks at hand. The TV is off and the monitor is swivelled out of view.[82] For the service user, the pregnancy is revealed in a different way and the woman may verbally receive the measurement of the pregnancy: "you're 10 weeks at the moment". But it is not merely the pregnancy that has been reconfigured. The measurement points to the service user herself, as the radiographer states, "*you're* 10 weeks at the moment" [emphasis added]. As the scan result is changed into figures to reference the pregnancy, these figures come to represent the service user, a sample of herself that then has the currency to determine which procedural trajectory she may be afforded – similar to the samples that represent the forest for Latour (1999). The service user has been categorised by the scan measurement and has, indeed, been represented by this measurement – a further variant of the pregnant-body discussed in Chapter 5.

Because the gestation of the pregnancy has been transformed into text, this text is able to travel in a way that exceeds the parameters of the uterus as part of the woman's fleshy body. The body is like a mobile laboratory, a travelling site at which different activities are

[82] Within the abortion assessment clinics at two local hospitals in Hull, UK, Graham, Ankrett and Killick (2010) found that the ultrasonographers preferred women not to view the scans out of concern about potential psychological effects of this and also because of the difficulty that they experienced from this situation. Recognising that Lyndhurst uses off-site ultrasound services, the sonographer that was interviewed as part of this study stated that, while women may ask to view the image, it was common practice within her workplace for staff to turn off the monitor visible to the women and her partner/support persons and that scanning was not offered as a choice to women as part of policy stating that "Lyndhurst prefers that women not see the scan". While the sonographer stated she had not seen this policy, it was standard practice.

conducted. Once the scan has been completed, the scan report can be sent off to Lyndhurst while the pregnant-body leaves the radiology service and goes home or to work or anywhere else. When the scan result enters Lyndhurst, the measurement in the report will fall on one side or the other of the marker of 7 weeks and 6 days, which is the point, at least initially, where a passage to medical abortion opens or stops, and where different sets of practices may commence.

An ultrasound scan serves as a diagnostic tool, and part of this involves working to identify the gestation of a pregnancy. For the option of accessing a medical abortion procedure at Lyndhurst, the scan must identify at least a 'gestational sac' within the uterus, which can look rather like a small 'black hole' residing in a picture of fuzzy black and white. In early pregnancies, a gestational sac may be too small or early to be 'seen' by the scanner and in turn the technician. In this way, much like the contraceptive devices discussed in Chapter 5, the technology of the ultrasound scanner can act back when it does not comply with the desires of other actors who rely on its clarity.

At Lyndhurst, I followed some of the communications concerning ultrasound scans when I sat alongside the receptionist. The following is a snippet of text from my fieldnotes of a conversation mediated by the receptionists' telephone:

> *"We go by the scan date" the receptionist says, "The GP's actually written you down as 7 weeks but your scan is showing 5 and a ½ and the doctors here go by the scan".*

The incoming caller was seeking to access an appointment at Lyndhurst and a date for a surgical procedure. But, the expectations of the caller were misaligned with what the service was able to offer. The caller has argued that she is already eight weeks pregnant according to the findings of the GP by way of an internal examination and by tracking the gestation of the pregnancy according to the first day of the callers' last menstrual period (LMP). However, the scan that Lyndhurst has received is showing something different. While at the time of the GP visit the caller's pregnancy was dated as seven weeks, the scan result has measured and dated this pregnancy as five and a half weeks gestation. It is the scan result that overrides the preceding modes of measurement. In this way, the scan result is an immutable mobile, it has turned the pregnancy into a document, and has fixed the gestation of the pregnancy where it is no longer open to conjecture.

The caller and the findings of the GP must acquiesce to this. This is also true for the receptionist. When she expresses that 'we' go by the scan, she is indicating that her capacity to

negotiate an appointment is determined by this result. Further to this, 'we' also concerns the doctors at Lyndhurst and the parameters within which they can perform an abortion procedure. In this way, through a snippet of text from a phone call, it is revealed that a multitude of actors must align themselves with the scan result in order to proceed with their specific goals. The service users are ordered and categorised according to these documents, but so too are the staff at Lyndhurst, where the care practices are mediated by the information that the documents provide (Berg and Bowker, 1997).

The reconfiguring of pregnancy into weeks and days on the scan report also determines the possible pathways through which the pregnant-body may circulate through Lyndhurst. Here a link back to the notion of time is important. As Strathern (2002) states, "Linear time is a way (but not the only one) to distribute powers and agency…" (p. 91). Accordingly, for the incoming caller, it is not merely a matter of occupying an unruly pregnant-body that is pregnant enough to move through an abortion trajectory. It is *how* pregnant a service user is that orders the access to services and availability of a procedure. One of the service users noted this link to measurement concerning access to either a surgical or a medical abortion:

> I38: Because I was so early on I got the option…
>
> (Interview 38)

Consequently, women seeking early medical abortions may be discouraged from having their scan too early and may also be required to repeat the scan in order that a 'gestational sac' is seen and access can be granted for a medical termination. A service user from Lyndhurst talks to this point below:

> I2: I knew I was pregnant but they couldn't…and I'd done tests at home and they were positive, but it was so early…because I'm so sensitive that I knew straight away that I was pregnant but they couldn't – they sent me for a scan – they couldn't verify it, which was awful…it was really early and um, because I knew immediately that I was pregnant and even that she was sort of sceptical, she couldn't tell when she [examined] me and the scan didn't show anything…
>
> (Interview 2)

Certification: Overlaying Divergent worlds

Realities are easier to produce in a transportable form (Law, 2004). Social workers, along with the wider multidisciplinary team at Lyndhurst, such as nurses and doctors, write into documentation to account for the work that they have done, and whilst doing so, are also writing in their professions, their organisations, and practices of decision-making (see Berg, 1996; Berg and Bowker, 1997; Callon, 2002). Callon (2002) has stated that the individual and the service are linked and "the link is woven by the plot produced by writing devices" (p. 200). In this way, the individual, at Lyndhurst, and the service and its staff, are connected in and through the *narrative* of the service documentation. Service documentation describes (and objectifies) the service and accounts for work done as much as it documents the patient journey. It is a particular account that is brought into being by melding selected threads of separate realities into one story. "*The narrative is the mediator that makes actions and their unity compatible*" (Callon, 2002, p. 200 [emphasis in original]). It is the compatibility of separate narratives that is key to the authorising of abortion and the process of certification that is the focus of this section.

The collective work of doctors, service users and documents must be translated into the form of a Certificate in order for movement through an abortion trajectory to occur. Certification of an abortion is vital part of a wider interplay between textual actors in a doctor's appointment that affords circulation of the service user through the service. With certification, there is no formulaic prescription by which this outcome is attained. Instead, certification is an achievement that arises from the compatibilities of two references –the service user's account of her decision and the paperwork containing the certification requirements (Latour, 1999). Like Latour's (1999) description of scientists laying multiple maps on a restaurant table to point to a specific site in the Amazon forest, certifying consultants superimpose multiple 'objects', - the words of the women, the ultrasound scan report, notes from the GP, and the grounds of the legislation in order to locate the point at which these 'objects' align. When they do this, abortion may be certified and consequently, this has the effect of enabling an abortion trajectory to move. However, whilst these actors are connected, at the same time they are configured quite differently – they come from different 'worlds'. Two short excerpts below, one from Latour (1999), and one from an interview for this study, are indicative of disparity.

> "They are talking about the soil and the forest. Yet because they belong to two very different disciplines, they speak of them in different ways" (Latour, 1999, p. 26).

> I21: I was surprised because I had to do two appointments to sign off before I could have the operation and see two separate doctors…I had decided.
>
> (Interview 21)

The first quote above from Latour (1999) speaks of the Amazon forest and how different disciplines - a botanist and a pedologist (soil scientist) - encounter the boundary between the forest and the soil (the savanna) in varying ways. These representatives of different disciplines cannot work out whether the forest is advancing or receding. They are talking about the same boundary, yet the botanist is responsive to the species of trees that are present at this boundary, while the pedologist is interested in the composition of the soil and its degradation from clay to sand (Latour, 1999). In a similar way, in the process of certification, the doctor, the service user, the gestational measurement of the pregnancy, abortion legislation, and the incomplete Certificate, come to this 'boundary' through different arrangements – as actors that have been assembled differently. This is evident in the second quote to do with certification. Here, a past service user notes the disjuncture between the requirements of two doctors' appointments and her decision, a decision that she has already made. Much like with the botanist and pedologist and their interest in the Amazon forest, the doctor and the service user are both invested in the goal of abortion. However, as noted, these different actors come to the certification process of abortion from different worlds.[83] Because of this difference, certification involves working out the fit between these worlds in order for certification to be achieved.

In New Zealand, abortion requires certification by two different doctors who have been assigned the role of certifying consultant. In this role, the certifying consultant must mediate the 'fit' between the reasons why a woman is seeking an abortion with the specific legal grounds, while also ensuring that the pregnant-body has been measured and tagged.[84] In this work they enact a combination of roles as the following informant describes:

> I18: Essentially I see that I have two roles: one is the operating side which is fairly self-explanatory in that I perform the termination of pregnancy, and the other side is the certifying consultant side which is assessing patients from a medico-legal aspect, so do

[83] Another possibility through which to look at the Certificate is as boundary object that mediates the coming together of different worlds (Star & Griesemer, 1989). However, the focus on movement and circulation calls for divergent attention to translation.
[84] The grounds for an abortion are not part of the CS&A Act, but are contained in the Crimes Act 1961 and two amendments passed in December 1977 and July 1978.

> they fulfil the legal criteria for having a termination of pregnancy and medically are they ok to go ahead and have a termination of pregnancy at Lyndhurst hospital.
>
> (Interview 18)

For a woman to move through the obligatory passage point of certification, a point where actors must converge, two signatures must be acquired prior to the performance of an abortion procedure. Instead of 'reading' the body through texts, or examining the flesh of the pregnant-body, the legislation calls for a narrative to be part of this set of practices.

At Lyndhurst, the practices of certification occur within the arrangement of a scheduled 'first' or 'second' doctor's appointments. In the small consultation rooms in which these appointments take place, should the doctor who sits at the desk, and the service user whose seat is located at the side of the desk, stretch out their arms they would be able to physically touch each other and the paperwork that is crucial to this engagement. The proximity of these actors infers that the doctor's role of authorising abortion does not occur without the other actors that are part of this arrangement. Yet, however close these actors may be in proximity, they are worlds apart. Links need to be made between the medical, service user, and legal worlds that have assembled together in order for an abortion trajectory to circulate further.

To certify abortion, doctors do not require the entire personal history nor the entire current personal circumstances of the service user. Rather, the doctors become sensitive to specific threads of the service user's story. This means that the appointment may unfold in ways that work to amplify certain aspects of the service user's circumstances, and at the same time, reduce the scope of this 'world'. The Certificate is a tool that assists with this endeavour.

Callon (2002) has discussed 'writing and (re)writing devices' as tools that help manage the tension between evolving complexities and simplification. Organisations, as Callon (2002) has argued, need to innovate and embrace complexities as well as the expansion of actors and negotiations to grow and be competitive. On the other hand, this complexity needs to be controlled – reduced and simplified - to manage this process and to profit from innovation. As Callon (2002) has suggested, "it is better to talk of the dual process of "complexification" (Mol and Law, 1994; Strathern, 1991) and "simplification" (Callon, 1986)… [tools that] encourage the profusion of actors and initiatives while also securing aggregation and ensuring that actors can be supervised and controlled" (p. 192). This dual process of expansion and reduction – complexification - is a feature of the certification process that is featured in an excerpt from a service user below.

> I5: When I was probably just conceiving I had taken some [pause] I'd taken ecstasy, and I had drunk a lot of alcohol on about two or three occasions over the January period. So, when I was really early pregnant I had had two or three occasions where I had excessively drunk. So [partner] was really really scared about that and the consultant I went and saw said she can't give us a termination on those grounds. So, you've got to have other reasons why to have a termination...And then we had a discussion for about 15 minutes about other things, financial reasons, wanting to be young for a bit longer, wanting to travel and things. And she said, right, this is getting more into it guys, because we'd sort of said we can't have this baby because of alcohol, I've just drunk too much alcohol, and she was really good because she said well you've got to take a few steps back, you don't make such an imminent decision because of that when there are a whole lot of other things to consider and this isn't definitely grounds for having an abnormal baby, this would not definitely cause your baby to be abnormal, she said its highly likely it is quite normal. So, um, yeah, so take a few steps back and think about other stuff...
>
> (Interview 5)

In the interview excerpt above, the goal of certification necessitates an opening up of the circumstances that the woman (and her partner) present to underpin their request for an abortion. The use of the aforementioned substances - alcohol and drugs – do not in their own right meet legal nor medical grounds in which to proceed with an abortion.[85] Thus, there is not a fit between the service users account and the grounds from which certification must occur. The doctor has encouraged the woman and her partner to "take a few steps back" and reflect upon the broader web of relations that have provided impetus for an abortion request at this time. Both the doctor and the service user work together to tease this out. In this way,

[85] In New Zealand, abortion has been a legal process following amendments to the Contraception, Sterilization and Abortion Act 1977 (CS&A Act). Currently, grounds for abortion up to 20 weeks gestation are part of the Crimes Act 1961 and amendments. These include:

- serious danger to life
- serious danger to physical health
- serious danger to mental health
- any form of incest or sexual relations with a guardian
- mental sub normality
- foetal abnormality (added in the July 1978 amendment).

Other factors which are not grounds in themselves but which may be taken into account are:

- extremes of age
- sexual violation (previously rape).

the differences between actors may be productive as it means that there is scope for working on something to try and find a resolution (Latour, 1999).

Once the wider world of the service user has been opened up, much of this must then be pushed away as the doctor is guided by the format and requirements of the document to sample selectively from the whole in order to bring this world closer to the paperwork that sits on the doctor's desk (Latour, 1999). In this way, concurrent to this amplification of the service user's account in this interview quote, the service user's 'world' must also be reduced and filtered. For example, Prior (2003) discusses the production of 'pedigrees', the information that is assembled to map the presence of cancer within a family. Similarly, the process of producing a Certificate within the abortion assemblage involves a process of mapping the service user's narrative where translation occurs from talk to text – from the narrative and the filtering of this into the writing that is inserted into the Certificate.

For the objective of certification, much like the way a blood test draws a sample of blood, doctors draw a sample from the world of the service user as this is made available from her account. But it is a specific sample that the doctor is listening for. As discussed, doctors are compelled to work not only with the service user, but with legislation. Accordingly, their engagement with service users is shaped by the demands of this text as a doctor explains below:

> I22: The only time it's ever been a problem is when occasionally you get these women who believe that it's abortion on demand, and they don't see why they should tell you, and they may well be right, that they shouldn't have to justify why they've decided, but unfortunately they do have to…I remember one girl…she said "I don't want to discuss this, all my family are doctors, I've had enough doctors sticking their two penith (Sic.) in" or something like that, "and I'm not going to discuss it with you". And then I had to say, "Well you do have to discuss it with me because it's illegal and I have to justify why".
>
> (Interview 22)

Doctors, like the doctor above, may present as powerful mediators of abortion access. At the interface between the woman and the legislation, and appear to be granted authority in this respect. However, doctors are still compelled to comply with legislation by justifying their decision in text. By determining which of the specific and limited grounds for abortion apply,

they must also translate the legislation into this certification process. The certifying consultant must add to this category of justification by writing into the documentation.

> I22: [We're] the people who interview the women and decide if there are legal grounds for authorizing an abortion - which is usually mental health grounds, and as long as you can establish that it would be detrimental to a woman's mental health, to force her to continue an unwanted pregnancy, then the abortion is legal. And it's quite likely that the law never intended that to be the case, but that's how it's interpreted. So, you don't have to establish a serious mental disorder, because it doesn't say that, it says that continuing a pregnancy would be damaging to her mental health, which, if a women wants an abortion and you refuse, that's damaging to her mental health…I always have been careful to write adequate notes, anyway. I always put it psychologically, … 'will be unable to cope psychologically if she was forced to continue the pregnancy', and if she's got depression, you would document that, because nobody's…there hasn't been a case, but you wouldn't want to be the first one because the notes were inadequate.
>
> (Interview 22)

While the practices of certification are not formulaic, they are inevitably standardised by the mechanisms of the Certificate – a complex assemblage of patient details, tick boxes, lines to insert the grounds of abortion and other textual details, as well as spaces for stamps and signatures. There are only a certain number of grounds for abortion that must be met in order for an abortion to proceed. In this way, the Certificate acts much like an inscription device in that it is a tool that can transform the presenting situation in the consultation room into the authorisation of abortion – but only if the grounds for abortion are met and inscribed. To continue to travel through service provision at Lyndhurst, the service user's decision must be translated into certification. Further inscriptions afford a clue to what is required for certification– reports of the grounds through which abortion is permitted. Of the grounds permitting abortion as described in the Contraception, Sterilisation and Abortion Act 1977 and in section 187A of the Crimes Act 1961, 98-99 percent of all abortions are performed under the ground of serious danger to the mental health of the woman (Statistics NZ, 2014). They must specify what the nature of this threat to mental health is.

> I18: I think that legally we do operate within the confines of the law and legal opinions that have been written up, as it were, and the most recent one was the end of 2006…you know the grounds of mental health…the new terminology now would not

> be 'reactive depression' but an 'adjustment disorder with depressed mood', and it was felt that that would fulfil the criteria, that if you had to continue the pregnancy that it would be likely to cause an adjustment disorder with depressed mood.
>
> (Interview 18)

The site of the doctor's appointment involves a cobbling together of partial-realities that manage to hang together well enough to not fall apart under scrutiny. This reality is not without controversies. A service user from Lyndhurst speaks to this:

> I32: That's what you need to do…I can't remember the terminology they use…plead maternal stress or, I can't remember what they called it, that's right, danger to physical or mental health…I discovered very personally that there is definitely not that equality in our society where we don't allow women to make that decision for themselves
>
> (Interview 32)

Like Mol and Berg's (1998) observations of divergent medical practices and its precarious relationship with science, the enactment of certification suggests that "medicine doesn't fail to meet the standards: the standards fail to meet reality" (p. 10). Because of the disjuncture that may arise in the practices of certification, and the ways in which poorly aligned realties may coexist, a concurrent process of amplification and reduction is required in order to overlay the divergent worlds of actors to provide a means to move forward. Rather than a rubber stamp, certifying is an exchange, a working back and forth, and a process of adjustment to arrange a fit between the circumstances of the service user and the legislation. To achieve the certification of abortion, doctors adapt their consultation and draw on inscription devices in specific ways that are relevant to this stage of an abortion trajectory. They are actively engaged in a process of translation.

Technologies as 'teaching devices'

The following section illustrates a further thread of translation where technologies are co-constructed as 'teaching devices'. Through the gathering together of a number of devices - a petrie dish, products of conception, a light box, and also human actors, Lyndhurst staff - it is possible to track some of the chains of mediations through which knowledge has been produced. Similar to the scientific reports in Latour's (1999) account, the words of the report and this knowledge has occurred in action and from the interplay between various actors –

through the sampling of soil and trees, tree tagging, and maps on a restaurant table. Later, on a desk in another part of the world, these samples are assembled and referenced in the writing up of a report. Concerning this set of relations, Latour (1999) poses an interesting question - "Are we far from or near to the forest?" (p. 36). The whole forest is not on the desk, this is an impossibility. Yet, through the samples that reference the forest, it is also possible to get close to it. The oscillation between closeness and distance, the references that can be made, and the knowledge that derives from this movement, is played out in the learning that is necessary to enact a medical abortion service at Lyndhurst.

The insertion of medical abortion, a pill-based early abortion method, into service provision involved a reconfiguration of actors and practices. This new assemblage of service provision added a further facet to nursing work where nurses were positioned more centrally in the performance of the abortion procedure. This inevitably necessitated that nursing staff acquire new skills. One of these 'skill packages' concerned working directly with the contents of the uterus. It would be the nurses who would be assessing whether a medical abortion was complete by sighting the pregnancy tissue and identifying the gestational sac of the pregnancy. Yet, initially, the prospect of doing, so rather than enriching the work of nursing staff, was prefaced by concern and uncertainty as the following nurse expresses:

> I28: We were really worried when we started that we weren't going to be able to know if everything was there or not, be able to make it out…
>
> (Interview 28)

As the nurse above indicates, the addition of medical abortion has evoked worry. Knowing if everything is there and making it out is a concern. How might one come to know and make out these substances of the uterus? If nurses are to oversee/manage the 'doing' of medical abortion, how might knowledge be acquired?

One way of transferring knowledge, or gaining new skills, is by observation. Namely, by looking at and seeing the materials of the uterus as they present as part of abortion provision. That is, not from medical abortion practices that are yet to unfold, but by borrowing from the practices and substances of surgical abortion. It is from the doctors checking of the products of surgical abortion that a temporal relationship is revealed. From the products of a surgical abortion, the doctor may find products of a similar gestation as would be expected from the medical abortions that are still to be put into practice. From this detective work of looking through, checking, and finding from her reference of the scan report and the many surgical

abortions she has participated in, she is able to put the products on display for staff to see. This is illustrated in the fieldnotes below:

> *There is news that Lyndhurst can go ahead with the first medical abortion. This has been authorised by calling a senior staff member at the main Women's Hospital on the telephone – the conversation is relayed to us – she said "as long as she's had good counselling around it I don't have a problem with it". This is good news. The implementation of a new service, the shift from the starting blocks, occurs with a phone call. No official letter, no meeting, no ceremony. A phone call. A call that indicates "go". And we are all involved. There will be a Day One on the Monday and a Day Two on the Tuesday. Staff will meet afterwards at 2.30pm to talk about the process and how things went.*
>
> *When I make my way to the meeting, a nurse catches me. "She's passed the pregnancy. It's there if you want to have a look at it". She directs me to the sluice room. The products of conception are on the bench in a shallow flat bottomed rectangular glass dish that sits on a light box on the bench. The nurse tells me that the woman has passed the products while going to the bathroom. This is as expected and the nurse explains that the product has been sieved to remove urine and some water has been added to enhance visibility. There is less product than I expected – the pregnancy was 6 weeks and 6 days gestation according to the ultrasound scan. The nurse covers the dish with the towel - my cue to exit.*
>
> *I go about making coffee when the doctor enters the tearoom. Have I "seen the products yet?" she asks. I say I have and would she would be willing to tell me a bit more about what I had seen. We walk down the corridor to the sluice room where the products sit on the bench. One of the corners of the towel has dropped into the watery liquid. The doctor removes the towelling, then puts on a pair of latex gloves and begins to explain. She refers to a laminated black and white photocopy of an image of products at a similar gestation but by a suction termination. In this photo the products were contained within a petri dish and sorted according to the type of tissue that is present. At the bottom of the picture was a written explanation. The doctor talks to this image and to the text but with reference to the tissue in the glass dish. The doctor says that while the products in the picture were not as intact, we can still see the parts of the pregnancy and compare the picture to the products in front of us. I see that the products in front of us have been reassembled and sorted in a similar way as the*

picture. The doctor explains that the round blob of light creamy-pink spongy tissue of about five centimetres in diameter was placental tissue and that at this stage the sac and embryo were inside this – this is what needs to be sighted for the abortion to be complete. She said that we might be able to see them and lifts out and stretches the placental tissue out in several places with her fingers. "I don't mind this sort of thing" she said. I respond that this was interesting to me also, which it was. I see two small bloody clots of blood not quite a centimetre square. She returned the placental tissue to the dish and pointed to another small clot which was revealed as the cord. There were additional bits of fragmented looking bloody, clotty tissue which the doctor explained was the decidua or lining of the uterus. I say that there is less product than I expected and the doctor explained that with a surgical termination, "obviously it is at a later gestation" but also she would be suctioning away most of the decidua. In contrast, with a medical termination, the "pregnancy" is passed "naturally" and the decidua would still come away over the following days for "up to two weeks". She adds that that was why women bleed for longer with a medical abortion than a surgical. She positioned this tissue which seemed partially connected around the placental tissue to indicate how this would be situated within the uterus and stated that the uterus then enclosed this assemblage of tissue. She then disassembled the tissue to its original positioning and removed her gloves. Two other members of staff joined us in the sluice room. With a wooden spatula the doctor proceeded to reassemble the products again for the two other staff. As other staff joined us, the room become cramped for space and I could no longer see the products. I thanked the doctor and returned to the staff room as I heard her repeating the explanation she had given me.

The knowledge that staff gain about medical abortion is accumulated in the *doing* of medical abortion – on the job, where staff have got close to medical abortion in action. Like with Latour (1999), a number of references, images, measurements, materials, assist Lyndhurst staff to "grasp the *practical* difference between the abstract and concrete" (p. 47). In the description above, the accumulation of knowledge occurs prior to the formality of a meeting and the talking about events that have been undertaken by viewing and working with the products of conception. The products that have been expelled from the uterus are implicated in the teaching – a teaching tool/device.

The 'whole' assortment of products are products without a uterus, without the women from whom the products came. It is by separating out specific parts of the body that staff are able to see and know about that which is usually contained within the body. The products in the

sluice room are representative and come to stand in for products generally. They are not only *this* woman's "products", the entire contents of the uterus, but an indication of what products at this gestation look like and what parts of the products cue the nurses who oversee medical abortion to discern whether an abortion is "complete".

> I20: Normally, the doctors don't look through…I think it's because [doctors name] is trying to educate the nurses about what to expect and what to look for when the Mifegyne® is up and running, so [doctors name] was checking to see if she'd got everything and she's always checking and if she finds one that's around the time, like an earlier on that's 6 or 7 weeks then she puts it on display for the other girls to see…
>
> (Interview 20)

In the sluice room, the doctor alerts us to two reference points. Firstly, the doctor references an image she has sourced from elsewhere that she uses to compare the tissue of the image to the tissue "in front of us". While the image is of the products from a surgical abortion, there are enough connections with medical abortion, a different procedure, to be able to decipher an assortment of tissue into its parts and to reassemble its parts as a whole and back again. Context is relevant. The 'whole' assortment of products are products without a uterus, without the women from whom the products came. It is by separating out specific parts of the body that staff are able to see and know about that which is usually contained within the body.

The products in the sluice room are representative and come to stand in for products generally. They are a single representative for the many products that will occupy this setting (Latour, 1999). They are not only *this* woman's products, the entire contents of the uterus, but an indication of what products at this gestation look like and what parts of the products that cue the nurses who oversee medical abortion to discern whether an abortion is complete: A guarantor when doubts are raised (Latour, 1999).

Secondly, the doctor makes a comparison from her experience of surgical abortion when she explains that there is less product with a medical abortion. The manual intervention on the uterus with a suction cannula removes more of the lining of the uterus than the uterus removes itself when stimulated to contract via medication. Medical abortion relies on the medication working on the body, and the response of the body to this, rather than the work of the cannula as facilitated by the doctor.

While connections can be made from a surgical to a medical abortion, and they can be referenced against the other, the connection of the doctor to the procedure has changed. The

doctor is involved in different ways. The doctor is less active in the performance of this medical abortion procedure and more removed – on the margins rather than central to this chain of events. This is a shift from the doctor's role in the previous section on Certification – in the process of circulation, her role changes as part of a medical abortion trajectory. Her role is reconfigured to one of overseeing a procedure that is facilitated instead by nursing staff and occurs, not from the actions of the cannula, but through the interactions between pills and the woman's body. With medical abortion, the pregnancy tissue is less ordered. The sighting of a gestational sac is a clear indication that the woman has passed the pregnancy, an object, a sample of the body, that can be visually referenced to show the procedure has been effective.

So, how do you implement a new service within existing service provision, and how do you know what to do? You get on with it, you try it, with no significant claims, overarching plans or expectations, to go ahead with what might be possible. You do it in action, as its happening, as part of the motion of events. You do it by doing, by observation, by attentive work with what is at hand, with the products that have also been 'worked' with - passed, sieved, sorted, parts gathered together, parts separated out. As Latour (1999) has argued, "Knowledge derives from such movements" (p. 39). Skills are developed in this way and a new medical abortion service begins to take form. This collective work and what this entails is discussed further in Chapter 7.

The pills that have been central to this set of activities appear to have dissipated. However, this is not the case. The point at which the pills stop acting is undetermined. In fact, in the relational work that has been described, the pills remain active – they have just been translated into other actions. As de Laet and Mol (2000) articulate, "Effective actors need not stand out as solid statues but may fluidly dissolve into whatever it is that they help achieve" (p. 227). In this way, staff may not *see* pills in their material tablet form, but they are engaged with their effects or the translation of the pills. Pills are implicated in the products of conception as a teaching device and the activities of producing of knowledge. The pills may have ceased acting on the body in that the pregnancy has been expelled, yet, their activity continues beyond the learning work that begins with medical staff and the work they do in with the pregnancy tissue - this site or version of medical abortion. Moreover, the learning staff acquire circulates further than the sluice room. It is integrated into additional sets of practices and other chains of action such as nursing, nurse aid, doctoring, social work and knowledge practices that extend to task-orientated and relational practices with further actors – other staff, other service users, documents that assert that any given service user has passed

their pregnancy, and other sets of products that are expelled from the uterus into other vessels.

Conclusion

In this chapter I have attempted to show some of the sets of practices and links between these practices that are imperative to moving through a trajectory of the abortion provision. The notion of 'circulating reference' by Latour (1999) was a key means through which to articulate some of these translations.

Diagnostic tools, such as the home pregnancy test and ultrasound scanners, were considered due to their part in further assembling the pregnant-body, and where the sampling of the body and translation of the pregnancy into form produced a diagnosis and measurement of pregnancy. As discussed, these actors alone do not afford circulation, rather it is the enrolment of further inscriptions that allow this to happen.

Attention to the process of Certification provided a means to follow the process of translation. Here the agency of legislation was revealed in that it was not doctors alone that authorise abortion, but the work between different actors, the legislation, the doctors and the service user that is key. This particular work involved the overlaying of different worlds in order to establish a fit between the narrative of the service user and the requirements of the legislation. To do this the doctor was required to move between amplifying and reducing the scope of this narrative. This movement did not occur without boundaries. The controversies of legislative grounds also played a part in shaping how abortion was authorised.

Finally, teaching devices were described, where the example of learning about medical abortion offered insight into the referencing of various devices alongside each other in order to produce new knowledge. Through the practices in the sluice room it was possible to see how the 'world' can be both close and distant.

A focus on medical abortion continues into the following chapter where a different type of translation is revealed. Instead of the work that secures moments and movements, the focus shifts to collective work and tinkering. The translations in this subsequent chapter describe the experimentation, adjustments, and improvisation that are embedded in care practices and intended to improve care.

Chapter Seven: On Technologies and Tinkering: The Little Pills that Could?

Introduction

In this chapter, I introduce this new abortion assemblage and follow the technological innovation of pills, which enabled a pill-based method of abortion at Lyndhurst –medical abortion.[86] In the already controversial assemblage of abortion, abortion pills are a further actor of contention (Clarke and Montini, 1993; Joffe and Weitz, 2003). ANT sensibilities enabled an exploration of the "tinkering" work (Mol, Moser and Pols, 2010) that is involved in the translation of medical abortion into abortion networks. This inclusion of a new abortion service into the abortion network reveals the instabilities and controversies in services of care.

The enactment of medical abortion involved a number of controversies. For example, the instability of technologies such as of pills and their effects on specific bodies, where medical abortion should take place, and which actors should be included or excluded from this assemblage. Mol, Moser and Pols (2010), offered *tinkering* as a means to articulate the ongoing ways that pills adapt the actors and practices they connect with, and the ways that actors and practices are adapted to work with pills. Further, like Law (2010) has discussed, this involved necessary experimentation and "improvisation" to not merely provide a new mode of care but to provide good care amidst the inevitable challenges of introducing a new service (p. 68). Inevitably, the reality of inserting medical abortion into service provision at Lyndhurst did not occur in the absence of tensions and problems.

The work that actors do together was evident in Chapter 6, particularly in the section on 'Teaching Devices'. Here an array of actors and practices were involved in the process of

[86] Mifepristone (*Mifegyne®*) is the key drug for medical abortion. It is this drug that is sometimes referred to as the 'abortion pill'. In practice, medical abortion, does not tend to involve 'an' abortion pill. Rather, medical abortion, for the most part, involves a set of discrete pills. It is a combined regime of pills that offers enhanced efficacy for a pill-based abortion method. Accordingly, in New Zealand, mifepristone was registered for use for medical abortion in combination with a prostaglandin analogue - misoprostal (Sparrow, 2001; 2004; Goodyear-smith, Knowles, & Masters, 2006). In some international locations, due to issues around access, availability and cost, misoprostol is used alone to induce abortion (Berer, 2005a).The medication(s) used, the dosage, route of administration and gestation of the pregnancy correlates with the effectiveness of the process, extent of side effects, and degree of risk (Berer, 2005a; WHO, 2006). For accounts of how medical abortion was introduced in New Zealand see Sparrow (2001; 2004) and (Sparrow and Shand, 2007).

learning about pregnancy tissue. This occurred through a sort of experimentation – of looking, referencing, and making links - in order to develop new competencies. This experimentation involved a different type of translation than that articulated in Chapter 6. It was an experimentation that focused on the collective work that takes place within care practices as well as the improvisations that are imperative for the provision of 'good' care. Instead of looking for the decisive moments and the movements that enabled a pathway through an abortion service, attention to collective work and the working back and forth between materials enabled staff at Lyndhurst to learn how pills combined with other actors to enact care.

Collective work in care settings, as Mol, Moser and Pols (2010) have discussed, involves a focus that is less attentive to the understanding of the roles and work of either doctors, nurses, or service users (for example), but is instead sensitive to the details of care practices and what goes on in the enactment of care. Following the notion of collective work, attention to the instabilities of practices may open up possibilities for understanding how care gets done - specifically and locally - at Lyndhurst.

By attending to care practices, it is possible to attune to the instabilities of care, and that 'good care', or indeed 'bad care' or care that is 'good enough', is not necessarily obvious or permanent and may in fact be uncertain and entangled (Mol, Moser and Pols, 2010). Care, good, bad, or otherwise, is emergent through collective work and arises out of the practices of the actors who are invested in it. This collective work and the aim of 'good care' is something that arises out of compromises and continual tinkering. Tinkering, as Mol, Moser and Pols (2010) have explained, is a form of "attentive experimentation" that takes place in care practices, or in the doing of care, to improve the quality of care provision (p. 13). This notion of tinkering as "attentive experimentation" is a useful tool for thinking about medical abortion and how this new pill-based procedure took form at Lyndhurst, particularly as it related to how it worked, what worked, what did not work, and what could be done better (Mol, Moser and Pols, 2010).In addition, how many actors were involved in this new abortion assemblage, and which actors were included and excluded from this assemblage in any given medical abortion arrangement, were also important issues for thinking about medical abortion. Before discussion of the collective work involved in the introduction of a new medical abortion service, a consideration of technologies and how these are 'taken up' in this account is important to the unfolding of this chapter.

In order to *do* the work of abortion provision, technologies have a crucial role. Indeed, abortion provision at Lyndhurst was absolutely dependent upon the technologies that populated this setting. For example, in Chapter 5, the hospital bed in theatre proved to be a vital technology for defining actors and their roles in theatre as well as playing a part in mediating the work that actors do. As a 'new' technology to abortion provision,[87] these pills are afforded credit for the work that they do and their significant contributions to care practices.

Shilling (2004) noted that the proliferation of technologies means that not only are they 'out there' in the world but they have moved inwards where varying technologies combine with the body to reconfigure the body and produce new bodily realties (Shilling, 2004). The advent of medical abortion at Lyndhurst provided an opportunity to follow how pills reconfigured bodies, and in this case changed the state of the body of the service user from a pregnant-body to a non-pregnant state. Further to this, the inclusion of pills into service provision at Lyndhurst had a role in reconfiguring abortion practices and the spaces in which these practices occurred.

This chapter discards a conventional society-technology dualism for the premise of 'mutual constitution' (Prout, 1996). Prout (1996) has argued in the case of the metered dose inhaler, a device involved in the management of childhood asthma, that engagement with technologies of care exceed the mere 'use' of devices. Instead, human and non-human actors are embedded in a set of relations where they mutually shape or constitute the other (Prout, 1996). It is not the case, then, that technologies and technological innovation impacts upon society as if it sits outside and is separate from it. Nor is the inverse true that it is 'society' alone that creates and shapes the technologies that populate social worlds and dictates how these might unfold into

[87] Medical abortion presents as 'new' for Lyndhurst, and inevitably for the service users who engage with this arrangement of care. The pill mifepristone, however, is not 'new' as far as its discovery is concerned, considering its origins can be traced to the 1970's in the laboratories of Roussel-Uclaf, France. Moreover, while there was interest in including medical abortion into abortion provision in New Zealand from the late 1980's, mifepristone was not approved in New Zealand until 2001 (Sparrow 2001; 2004). The process of acquiring and introducing Mifepristone entailed around two decades of negotiations by invested actors (see Sparrow, 2001; 2004). During the New Zealand Abortion Providers Conference in March 2008, speakers (including Sparrow and Shand, 2007) challenged abortion staff and service providers to update their practice, exert less medical power, and afford service users more agency regarding access to early medical abortion and the options of either medical or surgical procedures. There was a push for implementing early medical abortion, an identification of the services already providing the service and a direct challenge to those who were not providing medical to think about why. It was at this point that one of the Lyndhurst doctors, who acted as Clinical Director of Lyndhurst at the time, and attended this conference and was responsive and mobilised work to include a medical abortion service into service delivery at Lyndhurst.

the world or into a particular setting. As, Timmermans and Berg (2003) have argued, "traditional medical writings overestimate the power of technology to change society or underestimate the role of medical technologies, viewing them as mere tools to be socially situated" (p. 103). In concurring with this argument, rather than regard technologies are 'mere things' or overestimate their capacity, this chapter draws on ANT method to 'un-black-box' medical technologies. Within an abortion assemblage, 'abortion pills' and other pills that are enrolled to do specific jobs at different times (for example to provide pain relief), mutually shape care practices and those who contribute to them.

By attuning to technologies, this chapter also illuminates the uncertainties of technologies and their 'non-compliance'. As Mol, Moser and Pols (2010) have suggested, technologies may be seen to act and have effects on the care practices they are part of, they may also 'act back' and produce unexpected effects that must be attended to. In order to be responsive to technologies, then, this chapter is sensitive to the following recommendation:

> Do not just pay attention to what technologies are supposed to do, but also to what they happen to do, even if this is unexpected….If doctors and nurses want to learn about the unexpected effects of interventions, they should treat every single intervention as yet another experiment. They should, again and again, be attentive to whatever it is that emerges (Mol, 2008, p. 49).

The attentive work and experimentation that Mol (2008) refers to above emerges from her account of the attempts by professionals and patients to keep blood sugar levels stable in the management of diabetes. This work was assisted by a new technology, the blood sugar monitor, which readily measures blood sugar levels and was intended to avoid the occurrence of blood sugar levels that were too high. Prior to this technology, blood sugar levels were mediated by the laboratory and measured less frequently. The blood sugar monitor made blood sugar levels readily accessible and measureable by the patient themselves, thus shifting the regulation of diabetes to patients rather than doctors. As part of managing their own health, patients replaced the established dietary practice of avoiding sugar with the notion of "balance", where patients 'tinkered' and experimented with their eating choices (Mol, 2008, p. 48). Unexpectedly, an outcome of this reconfiguration of care was that the incidence of *hypo*glycaemia increased, where blood sugar levels have become too low. The technology of the blood sugar monitor, then, had unintended effects. The occurrence of this unanticipated problem also called upon the blood sugar monitor for a solution. Doubts about blood sugar levels can be clarified by measuring these levels with the blood sugar monitor, and via the

reading that the monitor provides, the patient can be encouraged to eat or abstain from eating for a time to manage their blood sugar levels and their health. Thus, the insertion of the blood sugar monitor required that others involved in care, such as patients and medical professionals, were attentive to what emerged from this intervention. A process of experimentation and collective work proved to be an essential component for enhancing the wellbeing and independence of patients with diabetes.

The qualities of the attentive work and experimentation that Mol (2008) describes with the example of the blood sugar monitor can also be seen to play out in the introduction of a new medical abortion service at Lyndhurst. This non-surgical pill-based method of abortion presented as an addition to the existing and established surgical abortion service. The inclusion of a new medical abortion assemblage at Lyndhurst involved care practices that were emergent, and where the engagement with the technology of 'abortion pills' and their effects proved to be experimental. In the 'doing' of medical abortion, 'tinkering' was revealed as imperative for implementing service provision. In this way, the implementation of a new medical abortion service did not 'roll out' into service provision in a linear fashion with its complexities resolved. Rather, it was by enacting medical abortion at Lyndhurst, and responding to how this mode of care worked (or did not), that this service took form and became established as part of the abortion network.

In the first section, I attend to how controversies were handled and the necessary adjustments that were required in order to achieve a 'successful' medical abortion. ANT offers a different way to think about controversies and the compromises and dilemmas encountered in the introduction of medical abortion. Compromise is not simply about one actor's wishes winning out over another's; rather it is concerned with the tinkering that is done and how actors can come together to produce a new assemblage that suits their diverse aims and needs (Mol, 2008, Wilson 2015).

The following section introduces the tinkering that was required to enact a new abortion assemblage. The technological innovation of abortion pills distributed care responsibilities, opened up new agencies for service users, and mobilised additional care pathways and care networks. Actors did not merely work within closed and settled arrangements, but were required to collectively and concurrently be responsive to the dynamic realities of service delivery and adjust care to meet specific situations. Care must be adjusted and actors may be selected and substituted when things don't go to plan. The failure of pills and the arrangements of required for accessing medical abortion are discussed in this section.

Finally, the transfer of knowledge, a translation as per the discussion of teaching devices in Chapter 6, is discussed when service users must assemble their own care when medical abortion moves to the home setting. This is not a linear transformation but is facilitated by the tinkering of care practices. Then, we are alerted to the mobility of a medical abortion procedure where in the absence of 'high-tech' equipment, abortion pills enable the body to move in and out of different spaces and sites. In order for abortion to be moble – to move across sites – actors were enrolled to secure 'good care'. These did not merely involve support people (such as partners, family or friends) but also other key actors, such as pain killers, telephones, information sheets, pain measurement – inscription devices. This changed the relations between actors. Moreover, it changed the configuration of care sites and enrolled informal care settings, such as private homes. This shift from the site of the clinic meant that a different patient-body is assembled and staff must now care at a distance. When medical abortion occurs at home, the collective work involved with care is not disestablished, rather it is reconfigured where the caring occurs together but apart.

Medical Abortion: Handling Controversies

The enactment of medical abortion involved a number of controversies. These included how to enact medical abortion and the possible conflicts that may arise. Where should this version of abortion take place – at Lyndhurst? In the service users home? And also, who and what should be included and excluded from this assemblage. ANT sensibilities enables a mapping of the tinkering work that is done in order to handle the various controversies that arise.

Medical abortion at Lyndhurst presented the potential to demedicalise abortion practices, to move these out of the clinic and to be reassembled elsewhere in the homes of women who would manage the procedure within the arrangement of informal care networks (Fiala, Winikoff, Helström, Hellborg, & Gemzell-Danielsson, 2004). Whilst the enactment of medical abortion did not necessitate hospital-bound modes of care and the engagement of networks of expertise for the duration of the procedure, in the early stages of the assembling medical abortion included the Lyndhurst clinic setting. However, the enrolment of the clinic into the assemblage was precarious, facilitated by agreeing actors – medical staff, pain measurement devices, rooms that sorted and contained service users, and collecting devices for pregnancy tissue. It also suited the practices and actors of surveillance – the service documentation, for example, that tracked the progress of care. However, medical abortion did not have to be assembled in this way. At least not entirely.

Technologies, like the pills that are central to this chapter, are not as "shiny, smooth and instrumental as they are designed to look" (Mol, Moser and Pols, p. 14). In Chapter 5, contraceptive devices were shown to be unpredictable and at times 'acted back' on the intentions of doctors and bodies who relied upon their use. Medical abortion pills act in much the same way. They are 'scripted' (Akrich, 1992) to act in a certain way and produce a particular effect - in this case, the expulsion of pregnancy. However, they may fail or they may mediate unexpected effects. Tools such as pills must be adapted to specific situations and this requires the flexibility of tinkering (Mol, Moser and Pols, 2010). This mode of tinkering is illustrated in the fieldnotes below. The health of the service user is not the concern in this passage, her physical wellbeing is intact. But things aren't going to plan:

> *I am preparing to leave for the day, taking my dirty coffee cup to the kitchen, when I am drawn into the conversation of the tearoom and the circumstances and worries about a service user who was at Lyndhurst for day two of a medical abortion. The nurses are not worried about the health of the service user per se, but, they are troubleshooting. The service user hasn't passed the pregnancy within the four hours in which this most commonly occurs. She was given some additional misoprostol, orally, but still hadn't passed it. While this wasn't outside of the parameters of reasonable time for this part of the process, it was around 2 o'clock and one of the nurses would be finishing her shift soon. Consequently this posed difficulties as far as staffing was concerned and the need to provide adequate care for the women who remained onsite. Fortunately, one of the doctors was still also onsite…Back in the tearoom, the debrief takes place. The doctor had conducted a vaginal examination and saw that the pregnancy sac was just sitting at the top of the cervix and it just hadn't pushed all the way through. The doctor was able to retrieve the sac, do a quick sieve then into a container with a bit of water so she could see it better and determine that the pregnancy had been passed, before she was off out the door. The nurses resumed care from here.*

The nursing staff that I encounter in the tearoom articulate some of the dilemmas of assembling medical abortion and the adjustments that have been made as part of this work. The anticipation is that for day two of medical abortion, the service user should pass the pregnancy within four hours, a timeframe that dictates a standard, a norm, or a bracket of time in which the medical abortion should be complete. But this has not happened. Medical abortion is unstable and pills as key actors can been seen to act back. Perhaps, as Willems (2010) has discussed, the pills are also alerting the staff to troubles.

Similar to the argument of Law (2010), who attends to the vastly different topic of care in the midst of fraught veterinary practices, "improvisation" proves imperative to providing good care amidst its inevitable glitches and challenges (p. 68).[88] It is done through trial and error, through informed experimentation, and through a process of *tinkering* (Mol, Moser and Pols, 2010). Because technologies and their users do not always act predictably, it was in the midst of *doing* medical abortion that unpredictable glitches proved to be an inevitable reality of service provision (López, Callén, Tirado & Domènech, 2010).

Making adjustments to this new mode of service delivery, and responding to inevitable 'glitches', proved to be a necessary component for assembling medical abortion. As Winance (2010) shows in the collective work that occurs between a disabled person, a physiotherapist and an array of wheelchairs, to arrange the person-in-the-wheelchair, care is distributed between actors and involves a process of 'successive adjustment' to work out the fit between the user and the wheelchair and the ways in which they are linked to the other.[89] Similarly, Moreira (2010) notes the shifts that may be required to provide care where, rather than a complete reworking of care practices, attending to uncertainties is managed by addressing "one problem at a time" (p. 134). In a similar way, the collective work undertaken within the Lyndhurst setting involved shifts and successive adjustments by actors as part of enacting medical abortion.

The prospect of glitches or 'troubles' may mean that care is enacted with caution. There is not one way in which 'good' care may be enacted; versions of care emerge from the work between human and non-human actors (Willems, 2010). At Lyndhurst, the potentialities of medical abortion were cautiously responded to as medical abortion practices were adapted. In this way, the tinkering that was key to implementing medical abortion was not wild, but exercised with restraint. In the first instance, medical abortion was contained within the Lyndhurst clinic setting. Yet, enacting restraint concerning how the service unfolded within this setting was not without its controversies.

> *I am in the tearoom with a doctor and the nurse manager. We are talking about our medical abortion service. "Perhaps we have made medicals more difficult than they need to be…" the doctor says "…in the Netherlands they send people home". "Level J [other NZ service] have started to send people home. They have a nurse following up at*

[89] Callon (2002) also employed this term, 'successive adjustment', to talk about the transformative work of collective action.

12 and 5pm with 24 cell phone access for women to make contact". "What about pain management?" "Well, women may need less pain relief because they're at home in a familiar environment. They can move around. They're not just sitting at Lyndhurst waiting and focusing on the cramping". "If I was a patient, I would want to go home" the doctor says.

There was more than one way of doing medical abortion. In the conversation on the tearoom, a problem is presented. Is the medical abortion service at Lyndhurst more difficult than it needs to be, too rigid perhaps? Links are made to global practices, to the Netherlands where they send people home. From this comment the conversation turns back closer to home. Level J in Wellington is sending people home and they have inserted other actors into their care practices to support this – a nurse and a mobile phone are identified as additions to this more mobile assemblage of care. But "what about pain?" says one of the actors in the tearoom. This is a problem that pushes back against the possibility of moving beyond the Lydnhurst setting. A counter to this is raised, a 'good' in the enactment of care - home is an environment that helps manage pain due to its familiarity and the space that may be claimed for the service user to move around in on their own terms. Further, being in one's own environment affords a variety of everyday stimulus, households tasks, hot water bottles, comfortable beds and couches are further actors, that can distract from pain in different ways than in the hospital setting, particularly when one is just sitting and waiting and focusing on the procedure itself. A home setting for the passing of the pregnancy offers a similar panacea to that the 'vocal local' offers in theatre (as mentioned in Chapter 5). 'Home environment local' does not have the same ring, but as a practice, it does appear to have similar effects, that of distraction from the occurrence of pain. There is more to consider to extend the spaces of medical abortion and mobilise the service into the homes of service users. In the initial quote for this section, attention is drawn to additional actors that play a part in the practice of medical abortion – a phone with a nurse to talk with at the end of it. However, it is not as simple as a home, a phone and a nurse; other actors must be enrolled, and further actors excluded:

I36: …And with women going home…that's why they have counselling, that is why they wanted to know all those things about an English speaking person at home, how far they lived away, that's all around the fact that if they get into trouble, if they have complications, they can get back into the service or there's someone available or whatever…

(Interview 36)

Actors do not merely work within closed and settled arrangements, or depend upon protocols and formulaic objectives, but must concurrently be responsive to the dynamic realities of service delivery. López, Callén, Tirado & Domènech (2010) in their study of a home telecare service refer to *securing practices* ("these make systems efficient and reliable while securing to produce guarantees to achieve a clear sense of continuity between what services needs and the resources mobilised to meet these needs"), and *caring practices* ("that constantly challenge and the protocols and codes of the system") (p. 74). Because incidents and unforeseen circumstances are normal rather than framed as exceptions, complete securing is impossible.

'Tinkering': Assembling an alternative version of abortion

Necessary adjustments to care can be complex and require compromise. This is something that Winance (2010) has noted in her account of the tinkering required to establish a 'good fit' between a patient and a wheelchair to produce a "body-in-a-wheelchair" (p. 100). The way in which care is done emerges through different demands and different events as a means to attend to a particular context or situation (López, Callén, Tirado and Domènech, 2010). This was the case at Lyndhurst where actors had to adapt, adjust, and compromise as medical abortion was (re)configured.

> I42: So if they want to look at doing more medicals which I know they do, like medical Friday, then they are going to have an issue with the toilets.
>
> (Interview 42)

With the existing toilets at Lyndhurst, the toilet doors opened inwards. Toilet doors than open inwards pose a risk. Conversely, when toilet doors open outwards, in the event that a service user becomes faint or dizzy or loses the capacity to open the door herself, staff are able to open the door without the risk that the service users body may block their entry and consequently their support. The toilet doors would need to be changed.

To enact medical abortion, there needs to be enough toilets, and a certain configuration of a toilet - with a door that opens outwards. At Lyndhurst, a toilet may alter the course of medical abortion – it may play a part in transforming service provision by accommodating medical abortion practices or it may present a dead end. A mundane object like a toilet, proves to be

significant, an actor, because in the absence of the latter arrangements it can hinder the inclusion of a medical abortion service as part of service provision.

Further to this, staff needed to adjust to the uncertainties of a medical abortion assemblage. A nurse at Lyndhurst speaks to this point:

> I28: …they've all been easy ones to start with and now we're starting to see, you know, the other week one wasn't successful… She went home, with clear instructions, came back the next day, nothing had still happened, so she's booked next week on [Lyndhurst doctors] list for a surgical but I think the day before she has to have another blood test and scan. Unless of course she passes something in that time...
>
> (Interview 28)

In the excerpt above tinkering is revealed in the selection and substitution of actors to the assemblage of care. When medical abortion is unsuccessful, the approach to care must be adjusted. Above, actors compromise by waiting and allowing time to pass. When this does not result in a successful procedure, medical abortion is substituted altogether for a surgical procedure instead. This reconfiguring of care is a further compromise, albeit provisional in order to meet the interests of the actors involved and secure a specific outcome of ending the pregnancy.

Tinkering as situational

'Good' care is something that is done, in practice, as care goes on (Mol, 2008; Winance, 2006). It is in active tinkering that tensions and problems are worked with, responded to, and where there are efforts to try something further (Mol, Moser, and Pols, 2010). Service users may be equipped with 'securing mechanisms' that work to ensure a smooth passage of care - such as the clear instructions that are articulated in the quote above - but these do little to guarantee specific outcomes as part of service provision (López, Callén, Tirado and Domènech, 2010).

While a body of knowledge might be established about how abortion pills work on female bodies, how they act on the body of any individual service user within the local context at Lyndhurst is a matter of experimentation. It is informed experimentation, but experimentation nonetheless. There are no absolutes. If the body is not responsive to the medication that has been taken, medical abortion fails. Consequently, if the service user doesn't 'pass something' within a certain timeframe, then a surgical abortion is deployed. As medical abortion works on the body from the inside out, medical professionals have little if

any access to the body parts concerned, nor do they have control over how the procedure progresses. There is much that is literally out of their hands.

> I36: The thing is you don't want to be managing medical terminations; you want women to be going away. I mean the only reason they're coming back is because it's new…And it's early. I mean the idea is that it's early so it's simpler as well…And thousands of women in New Zealand are having miscarriages and the majority of those women won't go anywhere near a hospital…So it's just kind of putting it alongside this, I mean it's a medically contrived miscarriage but the outcome's the same…And with women going home…that's why they have counselling, that's why they wanted to know all those things about an English speaking person at home, how far they lived away, that's all around the fact that if they get into trouble, if they have complications, they can get back into the service or there's someone available or whatever, but they're not anticipating that it's all happening at the service, you know, and it should be around demedicalising it. So instead of empowering women, Lyndhurst is wanting to take control of it. I mean are they making sure that all women deliver at Lyndhurst? They don't need to do that.
>
> (Interview 36)

Uncertainties

The prospect of medical abortion for any given service user is provisional and uncertain even when this service is integrated into service delivery. In this way, the addition of a medical abortion service at Lyndhurst presented the *possibility* of a different procedure to that of the surgical-normative mode of abortion provision. It is not a procedure for all service users nor a procedure that can always be offered as part of service provision.

Medical abortion must be identified as a desirable alternative to surgical abortion by the service user. Various criteria measures need to be met such as that illustrated in the certifying process in Chapter 6. Moreover, the service must have the capacity (rooms, medical staff, and time) to provide the service and the care that is necessary. "Good care," as Mol (2008) details, depends on persistent, shared tinkering with technologies, bodies and daily lives. A nurse at Lyndhurst talks to this point:

> I28: …we're a lot busier with them and I think that that's the bit, just working out where it needs to change how to do things just from the point of view that when the

> best time is to get women in, get the drugs for day two, so when it's coming into the tail end of the procedure it seems to be when it's really busy at the minute. So we're trying to figure the change in roles a bit in that we always use to have two people in theatre setting up but now we may just have one so the other one can help in the ward to take up what the person looking after the medical can't do so that we can work things a bit better. …Yeah, they're interesting and I think we're setting it up so the person who meets the lady on day one takes them through on day two which is quite good for continuity of care.
>
> (Interview 28)

One of the criteria that must be met to pursue a medical abortion was a good command of English. Why was this so? It is to do with communication and it is also to do with pain. We cannot see the pills directly but they are evident through these effects. Because a medical abortion involves the expulsion of pregnancy via uterine contractions, the sensation of stomach pain and cramping for the service user is expected and discomfort that may be strong, alongside bleeding, is normalised as part of the process. One of the nurses at Lyndhurst speaks to this:

> I23: Clinically we're taking recordings every hour and we're there when they need us, and assessing their pain, because that seems to be the recurrent thing and we talk about that on day one, that they will experience some discomfort…
>
> (Interview 23)

As the nurse above indicates, a regular assessment of pain is part of the role.[90] In this set of arrangements, pain is not typically an indicator of something gone wrong or 'bad', but may well be indicating that everything is going right. Service users will experience some discomfort as part of the medical abortion procedure (Berer, 2005b). So, pain may be a 'good' of sorts – a marker that things are proceeding normally. This is not to say that pain goes untreated. Painkillers are readily deployed to help make the pain manageable. Like a number of medical procedures, a very painful procedure, or too much pain or unmanaged pain is not good. It is difficult for the service user and it is difficult also for staff who are working to provide good care.

[90] Following the recording and measurement of pain is further part of the assemblage of medical abortion. However, this was not a set of arragments I had access to as part of my fieldwork.

The pain of a medical abortion, the nurses explain, can be "quite intense" for service users and this can be challenging to work with. When there is not a "good command" of English, the nurses explain, their work is more difficult. Pain can interfere with the way a woman might usually be able to communicate with nursing staff. When there is not a "good command" of English and the woman must communicate in a second (or third…) language, the capacity for pain to interfere in communication is greater. Pain may disrupt the communication. It becomes an obstacle to counter. A disruption to good care.

Moreover, the service user might have a support person with her who does have a "good command of English". But this is still not 'good' enough, particularly during stress and pain. Further to this, because a support person may not stay the duration of a woman's stay at Lyndhurst, it is the service user themselves who must hold this ability to communicate with nursing staff.

The criteria that a "good command of English" was needed in order to pursue a medical abortion was a pre-existing marker – identified before the service was rolled out. But at this early point it had not been practiced, and the impact of meeting this criteria or not was unclear. What was not discussed is how to measure a "good command of English" and how this was might be indicated. Once medical abortion started, there are murmurings that some of the doctors should "tighten up" on this criteria. Level J are "quite firm" on this issue. To not have a "good command of English" is a mode of exclusion from medical abortion. But what does it mean to "tighten up", or to be "quite firm". A line of sorts, however, has been drawn. The existing 'good' is not good enough. The command of English needs to be better, to mitigate the impact of pain on communication, to ease the difficulties of nursing the women who are having a medical abortion. To improve care. The practise of communication becomes medicalised and is measured, then, because of its relationship to pain, albeit in a somewhat *ad hoc* way.

But, I am left with uncertainties. Did this criteria of a 'good command of English' determine who is afforded the option of a medical abortion? Or, conversely, did those who were afforded a medical abortion in the early stages of service provision, ultimately assemble and determine this 'criteria'? Moreover, what counts as 'a good command of English'? What is 'good' enough? There is no test that ascertains 'a good command of English', this measure it is a decision made in the moment with the information at hand. Moreover, the term itself, 'good command of English', is vague. But, it is not vast. There is some scope for flexibility. This small marker, 'a good command of English', and a flexible one at that, illustrates that this new mode of

abortion, medical abortion, lent itself to experimentation rather than certainty. There is evidence of tinkering in the establishment of criteria. Benchmarks of inclusion and exclusion as far as access to medical abortion are mutable rather than riged as staff refine the scope of service delivery in practice.

If 'a good command of English' is not achieved as part of a medical abortion process at Lyndhurst, there is still access to a body. However, because pills allow the body to be more mobile and not constrained to the hospital bed, when a service user goes home for the latter part of the procedure, there is no direct access to the body. Further to the informal care networks and the proximity to the hospital that also contribute to the assemblage of criteria, care relies upon a telephone. This was present in feedback from a doctor following the first medical abortion to take place at home, and is indicated in my fieldnotes as follows:

> *…she had called the patient who had thought she had passed the pregnancy as she'd seen what looked like a cotton wool ball in the toilet. The patient also reported that it was quite a painful process but that she was ok.*

Care relies on communication. Without access to a body, staff must be able to care at a distance (Pols, 2012). The mobility of medical abortion necessitates this. Pain is not necessarily a good indicator of something being wrong, rather, it is a by-product of the procedure and may well indicate that all is well. However, when staff cannot assess nor intervene on the body and the pain directly, they rely on the safeguard that communication may exceed pain and actors such as telephones to enact this care at a distance.

Caring together-apart: Making Abortion Mobile

Abortion in pill form makes abortion as a procedure more mobile. Pills are a low tech device. Accordingly, they tend not to be complex to administer, they are very small and lightweight, and thus, they are readily mobile in their tangible form. Concerning this mobility, pills are readily transportable in modes of circulation outside of the body; that is, in small boxes and packets, pockets of Lyndhurst staff, hands, and little plastic cups, and when they are taken they swished down with water. Further to this, when these pills move through the body of the pill-taker themselves and act according to their design, they afford an additional layer of mobility that affects the process of treatment.

When the pills act on the body, their 'treatment' does not restrain bodies in the way that a more high-tech assemblage of medical apparatus may necessitate. It is the pills and their combining with the pregnant-body that does produces an intervention. This inclusion of pills into the body enacts a version of Harraways' (1991) cyborg, a socio-technical-body, where within the skin there is all that is needed to move the pregnancy from inside to outside of the body, from pregnant to stasis. In addition, these pill-taking bodies are able to be mobilised. Indeed, mobile bodies are better placed than immobile bodies concerning the comfort and efficacy of medical abortion, as indicated earlier in regards to the ameliorative attributes of the service user being in her home environment.

And it is not just the service user that is mobile, or the medical abortion, but nursing practices are also mobilised when they enrol telephones to conduct their work through their monitoring of the service user and their practices of care. Moreover, when abortion is transferred to the home of service users, it could be anywhere. The pills do not produce immediate effects but do so over time. In this way, within some arrangements, medical abortion may be somewhat invisible and private. In the early stages of a medical abortion, the service user may be able to go almost anywhere, at least locally, when the pills begin acting upon the body – it could be while picking up the children from school, getting some essentials from the supermarket, or attending to the tasks of the home environment.

Even contained or constrained within Lyndhurst, where care is more visible, medical abortion remains mobile within different clinic sites. At Lyndhurst, the mobile-body moves medical abortion from consultation rooms, to hospital beds, to chair to bathrooms. There is an anticipated but uncertain timeframe from when the pills have entered the body, until the pregnancy is expelled. Medical abortion is wherever the body takes it. However, outside of the clinic setting, the care practices to do with medical abortion require a transfer of care. This necessitates that knowledge about the procedure must be transferred to the service user herself.

To achieve a successful medical abortion, the service user must be configured to a specific method or 'programme' appropriate for its use (Latour, 1991; Prout, 1996; Woolgar, 1990). Similar to Prout (1996) and his account of the metered dose inhaler, I found that medical abortion not only generated new competencies for Lyndhurst staff - for example, like in the attention to the teaching and learning that took place in the sluice room in Chapter 6 - but it also generated new competencies and new tasks for service users and other actors enrolled into the assemblage. One of the tasks of health professionals is to hold a foundation of

knowledge, to build upon this, and ideally to pass this on to the laypersons that this information affects (Mol, 2008). As Moreira (2010) has discussed, collective expertise is assembled as new experiences are shared, as strategies of coping, and as relating to one another. The user can then make use of this repertoire of knowledge, care management, and relational work in order to look after herself.

For service users, the process of medical abortion necessitated an awareness and the monitoring of the substances of the pregnancy as they are expelled from the body. Staff must transfer knowledge. They must teach the service user how to read the sensations of her body – the cramping, the 'good' pain (although pain relief will be prescribed), the reality of blood and clots, the passing a fluffy cotton wool-like substance in the toilet that might indicate that the sac has been passed. The relevance of toilets for proving a medical abortion service is explained by the actor below:

> I42: … when you do a medical, to pass the products it's usually easier to do it in a sitting-on-the-toilet position. We have one single room with one individual toilet, because you have to put a pan underneath and expel the products into that pan.
>
> (Interview 42)

A toilet takes on a different role with medical abortion than merely the passing of bodily waste - urine and faeces. Contrary to a site that is visited to relieve oneself, a toilet becomes an actor. The doing of medical abortion does not merely concern the pills that are taken. Although they are, of course, crucial. When the pills of medical abortion act and the body of the service user responds, her uterus contracts. The service user involved in the medical abortion process must read her body and *feel* that her uterus is cramping and a perceived need to *pass* something. From this visceral input, she can then go to the toilet where she may pass the products. This passing of products is easier, the actor above describes, to do in a "sit-on-the-toilet position". One of the functions of the toilet according to the quote above, is to make things easier. To ease the medical abortion process the position of the body as if sitting on the toilet is useful. Moreover, it offers a means to collect the pregnancy.

At Lyndhurst, the service user will be told that whatever has developed of the embryo is usually contained within this ball but that sometimes separates, and that it is possible to see a small embryo - the development of this depends on the gestation of the pregnancy. In the social work appointment the service user will be asked whether she wants to see some sketches of foetal development. Also, the post-procedure bleeding is different in a medical

abortion and can last for around two weeks. This is because the uterus is not being manually cleared out as with a surgical procedure, but it is the uterus that is doing this work. The function of pills on the body mirrors the process of a miscarriage - a more 'natural' process as is argued in some forums (Fiala, Winikoff, Helström, Hellborg, and Gemzell-Danielsson, 2004; Ho, 2006), but less efficient than the suction cannula and curetting of surgical abortion.

Accompanying this transfer of knowledge was the spread of care practices beyond the staff at Lyndhurst to the service user herself, who would now hold a greater weight of responsibility for the enactment of the procedure. By mobilising her own support networks, and in the private spaces of her home, the service user is able to assemble a version of care that takes form more on her own terms.

When medical abortion at home advances the agency of service users, it shifts the care to the hands of those whom abortion most affects - the women and her networks. This brings to the fore human actors within this network. Medical abortion at home involves what Hirschauer (1998) calls the "*extra*medical unification of medicine", although in reference to the topic of sex change. In the case of medical abortion, this is where service users take charge of their own care in the context of private spaces, and enrol actors from their private support networks to form a 'team' of care laypersons who oversee the process of passing a pregnancy (p. 23).

Informed service users, in conjuction with other actors, are instrumental in mobilising their own care networks, managing pain, and assessing the products that are passed as part of the abortion procedure. However, various constraints may disrupt this intention. I recall one of my early social work assessments of a woman who wished to undertake a medical abortion at home where upon commencing this activity, a complication arose. It became apparent that, while the woman stated that she had support for the duration for the procedure, in fact, her support person had commitments of her own whereby she was needed to attend to her own family circumstances and the children for whom she was responsible for; the service users care network thus fell apart.

In this way, similar to what Winance (2010) describes, I adjusted my practices to afford a better fit between the medical abortion procedure and the support the service user required outside of the clinic setting. It is through tinkering that care arrangements may be "repaired", whilst at the same time they remain conditional in that the support person must be available and not merely identified (Moreira, 2010, p. 134). This tinkering of my practice was intended to improve care and work towards an improved care outcome (Mol, Moser and Pols, 2010). Thus, the activity of tinkering did not imply some sort of untethered flexibility. It was through the

acting back of the care networks that I assumed were in place that my practice as a social worker and member of a team at Lyndhurst became more refined. Hence, I discarded my assumptions about support and attuned to the specificities of what this might involve within any given network of service users.

Again, this 'acting back' may be thought of as in conflict with the implicit requirements of the process in relation to its users (Prout, 1996). However, such glitches are not necessarily deliberately oppositional, but occur in action and in the tinkering of care. A 'good' medical abortion service relies on the mutability of care practices and capacity to change how medical abortion takes form. So, in the provision of medical abortion at home, this was not rolled-out in a rigid manner, but evolved through the specific glitches that arose in action. Tinkering and experimentation is a continual process where the adjusting and evolving of care practices is a 'good' when it comes to service provision – a means to have things work better (Mol, Moser and Pols, 2010).

The assembling of medical abortion 'at home' involved the assembling of new care networks and practices. An abortion procedure that can take place in the home setting of the service user, requires the enrollment of support actors in mediating a self-governed means of care. However, the reassembling of practices is complex. It not only relies upon the efficacy of abortion pills, but alongside this, relies upon the abortion provider to coordinate this process, legislation that enables it to legitimately occur, and that the women medically and practically meets specific criteria, including her capacity to enroll specific support networks. A heterogeneous arrangement of actors and practices are required to implement medical abortion at home. In this way, the prospect that medical abortion may afford a more user-led abortion option is concurrently subject to local arrangements. Care remains collective and does not so much change hands as the weight of care shifts, and has much to do with the roles of the hands involved.

With medical abortion 'at home', medical staff provide less care. To be clear, they do not care less, are not careless, or less attentive, but do less 'hands on' work concerning the performance of the abortion procedure. This is 'handed over' to other actors. In this way, aspects of their roles, responsibilities, skills, and attending practices, change hands. Yet, at the same time, they are really no less accountable for providing 'good' care. Abortion at home is not merely the woman's responsibility – there are follow-up phone calls, blood tests, perhaps a further scan and follow-up appointment. Whilst one of the 'scripts' of the abortion pill is that it offers the possibility of self-managed care, this care is primarily ordered by health professionals, its

protocols, the regime of pills given, legislation, and how support may take form, rather than suddenly becoming a detached assemblage of care that the service user control themselves.[91] As Willems (2010) has discussed, technologies, such as the pills in this chapter, do not determine care but nor do they leave it entirely open. In this way, service users may have a hand in self-managing and enacting their own care when it comes to medical abortion at home; but this occurs with the overlay of care that has been tinkered with and crafted by others (Pols, 2010).

Conclusion

In this study, the insertion of a new medical abortion service at Lyndhurst was observed to be a "modality of tinkering" (Mol, Moser and Pols, 2010, p. 11). Unavoidably, the reality of inserting of medical abortion into service provision at Lyndhurst did not occur in the absence of tensions and problems. It is in active tinkering that tensions and problems are worked with, responded to, and where efforts to try something further is allowed (Mol, Moser, and Pols, 2010). Similar to the argument of Law (2010), who attends to the vastly different topic of care in the midst of fraught veterinary practices, "improvisation" proves imperative to providing good care amidst its inevitable challenges (p. 68). This account is not intended to expose ill-organised, haphazard arrangements of care, although at times this appeared to be the case. It is more about how a service might be worked into being. It shows that care practices are active, they are mutable, always emerging, never settled. Knowledge is extended, routines are established, but certainty remains elusive. The implementation of medical abortion was a dynamic process where this procedure is enacted and re-enacted with threads of variance that are mediated by the actors involved. Pills, bodies, nurses, doctors, time, medical techniques amongst other actors, mutually constitute medical abortion, or versions of medical abortion. As the medical abortion service took form, the "practical tinkering, of attentive experimentation" proved essential to developing the quality of care provided (Mol, Moser and Pols, 2010, p. 13).

[91] A 'script', as Akrich (1992) defines it, is an attempt to articulate to the various users of the technology how it might evolve in the settings to which it is intended.

Chapter Eight: Conclusion

Introduction

This thesis has offered a specific account of abortion in Christchurch, New Zealand, and of a reproductive health service, Lyndhurst Day Hospital (Lyndhurst). In and through a series of descriptive 'snapshots' I have traced some of the divergent ways in which abortion takes form. Even within the confines of the locality in which this research is set, I have shown that abortion is not a stable phenomenon, but mutable, multiple, and uncertain.

Figure 4. Lyndhurst Day Hospital on Montreal Street

Abortion controversies are threaded throughout the thesis. I have sought to stay with rather than resolve some of the tensions and controversies that a topic like abortion involves. Accordingly, I have explored how specific controversies were assembled and have argued that they do not exist on their own per se – but that controversies emerge in the relationships between human and non-human actors, through their interests, their disagreements, the compromises they make, and through the practices that bring them into being and give them form.

Conventional abortion controversies tend to centre on dichotomous perspectives on abortion. 'Pro-life'/'pro-choice' perspectives present abortion as one 'thing' - an entity in a particular form that actors can hold perspectives on. However, as this research shows, actors didn't adhere to one 'form' of abortion. The singular way of 'knowing' abortion through perspectives leaves little opportunity for attending to how abortion is *articulated* and assembled. Indeed, I have demonstrated that abortion exceeded conventional modes of ordering and instead I have presented multiple abortion realties, slippages between these, backtracking, and

contradictions. In Chapter 3 this was evident in the patchwork of co-existing and conflicting articulations of the 'abortion-related' pregnancy.

ANT sensibilities and the notion of 'slow research' allowed me to follow and take seriously the agency of both human and non-human actors that proliferated abortion networks. This provide me with an opportunity to trace the relations between these actors to account for how abortion was enacted in, and through sets of practices (Law and Singleton, 2013). This careful 'following' of actors provided me an opportunity to trace how abortion work was enacted within multiple sites of practice. For example, the practices of the sluice room made visible some of the specific nuances of abortion that I would not usually encounter. Participating in the practices of the sluice room offered me deeper analytical insights of the collective I was part of in spaces that were outside of the activities of my day-today working role. Moreover, as noted in Chapter 2, my sluice room encounters strengthened my membership as part of abortion networks.

ANT sensibilities help describe heterogeneous networks that are made up of many actors: people, technologies, texts, devices, artefacts, and institutions that can all be a part of an actor-network. Accordingly, what I describe in this thesis is a 'social' that is made up of patterned heterogeneous networks and is larger, and more layered, than just the people involved. For example, the gateway of Lyndhurst, the sluice room, the documents assembled in the Pathway of Care, and a box of foetal models were revealed to be intricate assemblages of human and non-human actors. It is the methodological approach of ANT that opens up the complexities of abortion networks – something that is not possible with approaches that employ fixed theoretical frames. Moreover, ANT offers an interesting method for social work research, as way of being responsive to the complexities of social worlds.

The methodological repertoire of ANT enabled me to be sensitive to the complexities and uncertainties of abortion. I experimented with different ANT 'tools as a means to 'get close' to the action and ask new questions about the divergent configurations of abortion that I encountered'. In Chapter 3, Latour's (2010) 'factish' enabled me to follow controversies and tease these out by accounting for how 'facts' were assembled by different actors, how different actors might seek to overturn these facts, and through what chains of action any given variant of abortion can be claimed to be 'true.'

In Chapter 4 I drew from Law's (2004) notion of 'method assemblage' in order to account for the absences and presences that were gathered together to assemble professional identity. The notion of allegory allowed me to unpack identity further, where by following both human and

non-human actors, such as nurses, service users, graffitied chairs, and old sphygmomanometers it was revealed that professional identity can be assembled by 'reading between the lines' when actors must 'make do' as Lyndhurst staff did with its premises.

The assemblages of abortion were shown to be unstable. For example, in Chapter 3, a plethora of 'wording' was taken up by different actors as they sought to articulate abortion. Further, in Chapter 4, I presented the instability of professional identity by showing how social work practices were reconfigured from optional 'counselling' to a routine 'psychosocial assessment'. And, in Chapter 7, the process of introducing a new medical abortion service, the tinkering and adjustment that prove crucial to 'good care' illustrates that abortion provision involves flexible rather than fixed care practices.

At times the networks of abortion seemed to gain some stability such as through the translations that occurred through the work of inscription devices discussed in Chapter 6. Here sets of practices and links between these practices enabled movement through abortion provision. Inscription devices such as a pregnancy test and ultrasound scanner translated the pregnant-body into an 'immutable mobile' - pregnancy test results and scan reports. These texts produce a different bodily reality – a pregnant-body and a measurement of the pregnancy gestation. They also provided a reference to the body through which pregnancy could be referred to. Within the same set of arrangements, actors were shown to 'act back'. For example, at times the practices of scanning would fail to determine the gestation of a pregnancy when this is too early.

In this concluding chapter I have the opportunity to reflect on the value of ANT sensibilities for understanding abortion networks – specifically, the assemblage of abortion practices within the particular setting of Lyndhurst.

It was not the purpose of the thesis to provide a series of conclusions or recommendations to be applied in other sites of abortion practice, but rather, implications are discussed in terms of research methodology, the performative nature of the text, and potential areas for future research to continue to follow abortion networks. What has been achieved in this descriptive account is a generation of new socio-material 'knowledge' about abortion and a demonstration of how a less conventional methodology might be taken up for social work research.

Developing ANT sensibilities

My engagement with ANT involved a significant shift from my social work training. Social work has always recognised the relationship between the individual and the environment. Yet for the most part, the focus has been on the social environment, rather than physical environment – and the materials and technologies that are significant to research and practice. What ANT offered as a research approach were other surprises – I was able to tease out and reveal some of the apparent mundanities of abortion provision – such as how the clinic gate or the shabby chairs and partitions of the waiting room at Lyndhurst played a part in identity formation. I was alerted to the active role of service documentation and legislation and by following these actors closely I became aware of how *things* give legitimacy to organisational work and professional identity. And I attuned to how medical apparatus and medication and their relationships with human actors exposed various power struggles between actors and actor-networks.

ANT sensibilities of 'slow research' and staying with the action, enabled me to be sensitive to 'ethnographic surprises' and the uncertainties that present in the course of the research journey (Law and Singleton, 2013). For example, in Chapter 5 I discussed contraceptive devices, the material actors that were enrolled to bring order to the unruly body. By following these actors I was alerted to unexpected forms of power that determined practice arrangements. For example, contraceptive devices were shown to 'act back' and disrupt attempts to tame the body when they failed or were absent from a body assemblage.

I have noted in Chapter 2 that ANT does not pursue conventional notions of power, gender, class or agency. By studying assemblages I have illustrated that agency, or action, is distributed (Law and Singleton, 2013). For example, Chapter 5 showed that even in the arrangements in the operating theatre at Lyndhurst, the patient-body is not rendered passive – the patient is also active in the enactment of the body – by putting legs in leg supports, and talking with staff. She is not, as Latour (2004) has suggested, turned into a "mere package of objective meat". Instead, the patient-body is indicative both of the subject-object entanglements. Understanding power as an effect of a network has enabled me to undertake an examination of practices of power outside the conventional analyses that have focused on structure and gender.

As I engaged in the activities of 'slow research', ANT allowed me to follow different actors, to move between sites, and explore some of the diverse practices that abortion was made up of. By not predetermining a frame or perspective through which to view abortion I was able to follow both human and non-human actors to account for the work these actors did together on their own terms. ANT's inclusion of non-human actors and its focus on tracing the relations between actors enabled me to be responsive to both *who* and *what* played a part in assembling abortion. Moreover, ANT-inflected research and its principle of symmetry between non-human and human actors enabled a fresh approach to exploring abortion assemblages. Guided by Law (2004) I sought to allow multiple and messy abortion realities to be visible.

With this account of abortion, the descriptions provided offer both a story about abortion – a particular reality, and a kaleidoscope of realities that are nested in the specific and local relationships through which they emerge. Accounts, like Radley and Billig (1996) argue are produced relationally – each descriptive snapshot of abortion has emerged from how any given actor or actor-network is shaped in and through its relations to other actors and actor-networks. In this way, other research strategies, methods and modes of writing would have inevitably provided alternative accounts. Accordingly, attention is given to reflexivity in order to explicitly account for the means through which this version of abortion is assembled. With an ANT approach, the researcher features as part of the landscape. I was definitely a part of the landscape of my research – and I am left wondering if, having been part of it, I actually ever left it.

Abortion as heterogeneously assembled

The methods and tools I have selected as part of the repertoire of ANT devices have facilitated an analysis and description of abortion as a collection of dynamic socio-material relations and practices. An 'ANT-inflected' (Law and Singleton, 2013) approach to gathering data, analysis, and writing, afforded the unpacking and revealing of some of the complexities of abortion and of various abortion configurations.

In this thesis, I sought to highlight how abortion is made up of an assortment of people and things – or different 'actors'. In Chapter 5, attention to practices revealed that various bodily enactments are generated in specific heterogeneous relations. For example, the textual body was assembled from different sets of relations, materials and practices. Sites such as Lyndhurst, GP surgeries, medical laboratories, and radiology settings as well and non-human

actors such as referral letters, blood test results, and ultrasound scan reports as well as human actors, such as receptionists, doctors come together to produce a textual-body.

Multiplicity

In this thesis, I have drawn from Mol's (2002) concept of multiplicity as a means to be responsive to differences and the divergent ways in which abortion takes form. Service users, social workers, doctors, nurses and a plethora of other actors, will run into differences in how they encounter abortion and how they articulate what abortion is. These actors might all be involved in the provision of abortion, in one way or another, but they undertake very different practices, even within the same space.

In Chapter 5, for example, I unpacked different versions of the body. Here, the pregnant-body, the textual-body, and the patient-body were heterogeneously assembled and emerged in divergent configurations. For example, the textual body at Lyndhurst comprised of an array of texts – a referral form, blood test, and swab results, and an ultrasound reading that assembled a version of the body that could be interacted with in the absence of the patient-body, a different bodily assemblage.

Following the notion of multiplicity, the body was not assembled from the same sets of practices for each of these actors in this textured event. The service user and the doctor for example, do not have a different perspective on the abortion procedure in the operating theatre, but are engaged in an entirely different set of practices and come from vastly different worlds. These worlds may align, or as Mol (2010) suggests, what may be present is different "networks", that exist simultaneously in tension.

Offering a description, not an explanation

The value of this thesis is located in this descriptive account. With ANT, description is the means for accounting for this work rather than by way of explanation (Latour, 2005). There is an emphasis on accounting for action. The focus of a descriptive account is on emphasising the 'how': how actors frame their worlds, how worlds are generated, ordered, and configured.

As Austrin (2005, p. 148) has noted "When Latour follows scientists, as in Laboratory Life, or failed innovators, as in Aramis, it requires him to innovate too, through constantly assembling and reassembling the materials at hand. Writing then becomes part of this assemblage itself: not a report on fieldwork as a set of stabilized research findings but a process of translation and stabilization in its own right – a circulating reference, to use Latour's term."

Ultimately, this thesis is an partial account of the messy world of abortion services in Christchurch, New Zealand. It is incomplete because it is impossible to describe every detail of every aspect of this assemblage (Kerr, 2010; Law, 1993). Moreover, there are always aspects of abortion that are changing, and networks will continue to evolve regardless of whatever endpoint is established.

As there is no fixed end to a network (Kerr, 2010; Strathern, 1996) I, as the researcher, was left with uncertainties about the timing and process of exiting the research, exiting the analysis, submitting this thesis. Latour's (2005) answer to this frequently posed question is to stop when the participants stop or when the demands of the inscription being written are completed. An actor network can exclude certain components (Strathern, 1996), and in Kerr's (2010) study the "other" disciplines of fitness or hip hop dance were not considered gymnastics by actors in her research. Therefore her descriptive account of gymnastics assemblages did not follow those disciplines.

Similarly, the abortion networks could have been followed further than they has been within this thesis. It was possible to follow the referral of Lyndhurst beyond the clinic gate to the practices of second trimester abortion at Christchurch Women's Hospital. Or, the occasionally links that were made to later abortion services in Australia. Or, to the controversies of access for Southland women who at the time had no access to abortion services in their own locality and had to be referred to other services including Lyndhurst. Or different reproductive procedures. There are many ways in which this research could have continued, however, at some point, practically, financially, emotionally, and academically, it has to stop. In this thesis, through following assemblages of abortion services in Christchurch, New Zealand, I contained this research to first trimester abortion, to the local settings, to the completion of a research process and to the timeframe in which this thesis must be submitted.

Controversies, Instabilities and Reconfigurations

In Chapter 1, I began by providing some 'snapshots' of how I encountered abortion. I noted how reflective glimpses of the researcher's engagement with the research journey is a typical feature of an ANT account (Law and Singleton, 2013; Mol, 2008; Wilson, 2015). Similar to Mol's (2008) approach of presenting 'snapshot' accounts, I too incorporate reflexive threads of my experiences of 'wrapping up' this thesis and 'exiting' abortion networks. A quote from Latour (2005) is particularly useful to consider in this regard. Latour (2005) has stated, "We start in

the middle of things…Action had already started; it will continue when we are no longer around" (p. 123). I included this quote in Chapter 2 of this thesis in order to articulate the ways in which entry to the field occurs in the middle of the action. As I noted above, a dilemma of research, concerns the beginning and end of a network. The same dilemma is true for exiting.

Prior to the Christchurch earthquake, and for the duration of the fieldwork phase of this study, as noted in Chapter 1 and 4, Lyndhurst operated as Lyndhurst Day Hospital from a converted villa, set in a cottage garden with an abundance of roses, peonies, perennials, ornamental and fruit trees (Figure 8.0). After the 2011 earthquake, Lyndhurst, the building on Montreal Street, was abandoned. The assemblage of abortion was relocated to new premises with Christchurch Hospital. In early 2016, I noticed building activity at the old Montreal Street site – I drove past this site most days. Outer walls were repainted, heavy machinery cleared the hedges and gardens and a new fence ran the perimeter. Intermittently I would talk with someone from the old Lyndhurst and we would puzzle over the activities we were noticing - the dismantling and reconfiguring of the site that we were familiar with but no longer frequented. We wondered what would be assembled there, and surely, they didn't just dispose of all the old roses. A wooden fort and a large steel swing were clues but the addition of signage confirmed the reconfiguration of this part of the abortion assemblage and the inclusion of other actors that were part of a new assemblage related to children with delayed development and/or disability.

As I got ever closer to the submission of this thesis I decided to stop at the old Montreal Street site. The ANT sensibilities I had developed provided me with the impetus for documenting my snapshots of the transition of this building and ultimately, my departure from the research. I was reminded of the questioning by Latour (1999) in his account of the Amazon rainforest when he asked if the field or near or far. While I was close to the premises of the abortion assemblage I was part of, these premises were no longer part of this assemblage. The abortion networks I knew had been reconfigured and thus, 'the field' was a distant reality.

Figure 5. The gate to Lyndhurst Day Hospital, Montreal Street (above). Photo: Maria Buhrkuhl

Figure 6. The new gate to 440 Montreal Street (below).

When I arrived at 440 Montreal Street, there were new and old actors present. Before I entered the gate, I could see that a tree by the gate had grown over the fence, and others were no longer there – they have been removed. I noticed the same (but newly painted) corrugated iron fence and a new gate (Figure 8.3). There were no pamphlets, no protestors.

When I entered the gate, there was no sign for trespassers. This was a new health assemblage. I entered the building through a newly constructed entranceway that opened up into a reconfigured waiting room. The old carpet had been replaced with new carpet tiles – there were no coffee stains or grey/green partitions in the waiting area. Instead, situated on one side there was a blue couch and coffee table. On the other, some chairs and a book shelf with children's books stacked on its tiers. This reminded me of the sharp contrast I noted between Christchurch Women's Hospital and Lyndhurst in Chapter 4:

The premises at Lyndhurst are in contrast with a newly built Women's Hospital at another Christchurch location. Unlike the new hospital and its distributed array of services, Lyndhurst was not purpose-built for providing abortion services. Abortion provision made its place within an existing configuration of spaces. Whilst the spaces and materials were adequate to provide the services that Lyndhurst was assembled to offer, it is also the case that material mediators can disrupt professional identity when a service must 'make do'.

I had been invited to 'tour' the new service by the manager. I noted that corridors had been shifted and I was a little disoriented. When we came to a room with a stainless steel sink, the manager catching me raising my hand to my lips asked me, "Do you want to see the old sluice room?" It is not a sluice room any more, but an office with bright files on the shelves. "I bet you remember this room" she said as we walk into the old operating theatre. The space is clear and cameras are set up. It is now used to evaluate the walking and movement of the children. She commented, "We had each room cleansed and blessed. There were lots of tears that day". The controversies of an abortion assemblage made present in the materials of the premises had been made absent with the practices of cleansing, blessing, and crying. These rooms are now reconfigured for different purposes.

We chatted about the building, and its configurations. My return to the Montreal Street revealed some the new configurations and the new actors that had been enlisted into a new health assemblage. ANT provides an ideal set of sensibilities for mapping the changes that occur in assemblages such as abortion. The building that I have referred to above provides an example of the instability of networks and also of an actor that has entered multiple actor networks. The building had been part of various assemblages. It had been a rest home for older women – one of the staff used to work there, the manager told me. The building was also maternity hospital – my uncle was born there. It was then an abortion clinic. Now, a child development service.

With ANT, the entry to and exit from the field are rather arbitrary. I started this study within an existing abortion network and this network has since been reconfigured. My description of this network can only then offer a glimpse into abortion practices, their controversies, instabilities and reconfigurations. As described, nothing is fixed. Networks continue.

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